DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHAPTER 106
HEALTH CARE FACILITIES
Subchapter 1
Certificate of Need

37.106.101 DEFINITIONS (1) For the purpose of this subchapter:
(a) "Current state health plan" means the compilation of components containing guidelines for determining need for health care facilities and services subject to certificate of need review that is most recently adopted by the governor and a statewide health coordinating council appointed by the governor; a separate component adopted by the statewide health coordinating council and the governor for a single type of service or facility is part of the current state health plan.

(b) "Health service" means a major subdivision, as determined by the department, within diagnostic, therapeutic, or rehabilitative areas of care, including alcohol, drug abuse, and mental health services, that may be provided by a health care facility. Specific treatments, tests, procedures, or techniques in the provisions of care do not, by themselves, constitute a health service.

(i) "Health service" includes radiological diagnostic health services offered in, at, through, by, or on behalf of a health care facility, including services offered in space leased or made available to any person by a health care facility except when the capital expenditure for the addition to or replacement of the same service is less than $750,000.

(c) "Major medical equipment" is defined as provided in 50-5-101, MCA, and the department interprets the phrase "substantial sum of money" in that definition to mean "more than $750,000".

(d) "Swing bed" means a licensed hospital or medical assistance facility bed that is also certified for the provision of long-term care pursuant to 42 CFR 482.66.

(2) The following terms appear in the Montana Code Annotated, are not defined in the statutes, and are interpreted by the department to mean the following:

(a) The phrase "enforceable capital expenditure commitment", as used in 50-5-305, MCA, means an obligation incurred by or on behalf of a health care facility when:

(i) an enforceable contract is entered into by such facility or its agent for the construction, acquisition, lease or financing of a capital asset;

(ii) a formal internal commitment of funds by such a facility which constitutes a capital expenditure; or

(iii) in the case of donated property, the date on which the gift vested.

(b) The phrase "office of a private physician, dentists or other physical or mental health care professionals, including chemical dependency counselors", used in 50-5-301, MCA, as an exception from the definition of "health care facility", to mean the private offices of those professionals, whether practicing individually or as a group, and associated facilities that are:

(i) located on the premises of the professional's offices;

(ii) operated as an integral part of the professional's private practice; and

(iii) primarily available only to the professionals whose offices are located on the premises. Such facilities may include outpatient services and observation beds, but may not include inpatient services. (History: subsection (2) is advisory only but may be a correct interpretation of the law; Sec. 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-101, 50-5-301, 50-5-302, 50-5-304, 50-5-305, 50-5-306, 50-5-307, 50-5-308, 50- 5-309, 50-5-310, 50-5-316 and 50-5-317, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

Rule 02 reserved

37.106.103 LONG-TERM CARE: WHERE ALLOWED

(1) A health care facility, as defined in 50-5-301, MCA, may provide longterm care only if:

(a) it is licensed to provide the level of care in question; or

(b) it has received certificate of need approval pursuant to ARM 37.106.126 for the establishment of swing beds, is certified to provide long-term care in such swing beds, and the provision of long-term care is limited to such swing beds.

(2) A hospital may provide long-term care only if:
(a) it has received certificate of need approval from the department for the establishment of swing beds, is certified to provide long-term care in such swing beds, and the provision of long-term care is limited to such swing beds; or
(b) whenever the number of beds in which long term care is provided is five or fewer, the facility is certified to provide long-term care in those beds as swing beds, and the provision of long-term care is limited to such swing beds. (History: Sec. 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-201 and 50-5-301, MCA; NEW, 1986 MAR p. 38, Eff. 1/17/86; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)
Rules 04 and 05 reserved
37.106.106 SUBMISSION OF LETTER OF INTENT
(1) Any person proposing an activity other than those to which (3) and (4) below apply and that is subject to review under 50-5-301, MCA, and not exempt under 50-5-309, MCA, shall submit to the department a letter of intent that contains the following:
(a) name of applicant;
(b) proposal title;
(c) a detailed statement outlining whether the proposal involves:
(i) the addition of a new service, and, if so, an estimate of the annual operating and amortization expenses required to provide it;
(ii) the construction, development, or other establishment of a health care facility that did not previously exist or is being replaced;
(iii) the construction, remodeling, renovation, or replacement of a health care facility requiring a capital expenditure of more than $1,500,000;
(iv) a change in bed capacity through an increase in the number of beds or a relocation of beds from one facility or site to another;
(v) the expansion of a geographic service area of a home health agency;
(vi) the use of hospital beds to provide nursing or intermediate developmental disability care and, if so, the number of beds involved; or
(vii) other (explain);
(d) a narrative summary of the proposal;
(e) an itemized estimate of proposed capital expenditures, including a list of proposed major medical equipment with a description of each and the cost of the construction of any building, including remodeling, necessary to house it;
(f) anticipated methods and terms of financing the proposal;
(g) effects of the proposal on the cost of patient care in the service area affected;
(h) projected dates for commencement and completion of the proposal;
(i) the proposed geographic area to be served;
(j) an itemized estimate of increases in annual operating and/or amortization expenses resulting from new health services;
(k) the location of the proposed project, including its street address;
(l) if the person desires comparative review of their proposal with that of another applicant, the name of the other applicant;
(m) the name of the person to contact for further information, including city, state, zip code and telephone number; and
(n) the dated signature of an authorized representative of the applicant.

(2) For letters of intent submitted under (1) of this rule, in determining whether or not a capital expenditure for equipment is over $750,000, the department will review the list submitted by the applicant pursuant to (1)(e) of this rule and will include in the cost calculation the cost of any support equipment necessary to the proper function of the item of major medical equipment in question.
(3) Any person or persons desiring to acquire or enter into a contract to acquire 50% or more of an existing health care facility (whether through a single transaction or by adding to a portion already owned) must submit to the department a written letter noting intent to acquire the facility and containing the following:
(a) the services currently provided by the health care facility and the present and proposed bed capacity of the facility;
(b) any additions, deletions, or changes in such services which will result from the acquisition; and
(c) the projected cost of care at the facility compared to the cost under the current ownership, as well as any other factors which may cause an increase in the cost of care.
(4) Any person proposing to increase or relocate from one facility or site to another no more than 10 beds or 10% of the licensed beds must submit to the department a letter of intent containing the following as one of the conditions that 50-5-301(1)(b), MCA, requires to be met in order to be exempt from certificate of need review for the change:
(a) the licensed capacity of the facility, the number of beds to be added or relocated, and in the latter case, the facilities or sites in question; and
(b) the cost of the addition or relocation and its likely effect on the cost of patient care.
(5) As required by 50-5-302(2), MCA, persons who acquire health care facilities but who do not file the notice of intent required by (3) of this rule are subject to certificate of need review for the purposes of this subchapter. (History: Sec. 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-301 and 50-5-302, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1984 MAR p. 27, Eff. 1/13/84; AMD, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.107 SUBMISSION OF APPLICATIONS

(1) An application will be accepted only after submission of a letter of intent.
(2) The deadline set by the department for submission of an application will not exceed 90 days unless the department and all affected applicants agree to a longer period.
(3) No application for a proposal will be accepted earlier than the deadline set by 50-5-302(5), MCA, for receipt of a letter of intent requesting comparative review with that proposal, with the exception of a proposal for which a letter of intent was submitted requesting comparative review with an earlier proposal.
(4) The application must contain, at a minimum, the information as specified by the department pursuant to ARM 37.106.133 and 37.106.134.
(5) The original and six copies of the application must be submitted to the department.
(6) If the application is received without the full fee ($500 or 0.3% of the application's projected capital expenditure, whichever is larger), it will not be considered submitted to the department until the date the full fee due is received by the department. The fee must be paid by check made out to the department of public health and human services.
(7) Within 20 working days after receipt of an application, if the application is determined to be incomplete, the department shall notify the applicant in writing by mail

of that fact and of the specific information that is necessary to complete the application. The department shall also indicate a time, which may be no less than 15 calendar days, within which the department must receive the additional information requested. Within 15 working days after receipt of the additional information, the department shall determine whether the application is complete.

(8) If an applicant does not submit adequate information within the time specified, their application will be considered withdrawn.

(9) If the applicant materially changes the proposal or the capital expenditures projected are increased by 15% or $150,000, whichever is greater, after the department declares, the application complete, the department may cease review of the original application and require the applicant to begin the process again by filing a new letter of intent for the revised proposed project if it desires a certificate of need for it. If, after the department gives the applicant notice that the department considers the original proposal so altered that the review process must begin again, the department will continue on the original review schedule if the applicant notifies the department that it chooses to have review continue on the original application, rather than to commence a new review process on the revised application.

(10) The department may, in its discretion, conduct a comparative review of competing applications if such applications are being reviewed concurrently, if such comparative review can be conducted consistently with all other time constraints imposed by Title 50, chapter 5, part 3, MCA, and this subchapter, and if, as required by 50-5-302(12), MCA, they pertain to similar types of facilities or equipment affecting the same health service area, subject to the limitation that a proposal for which a letter of intent is submitted requesting comparative review, pursuant to 50-5-302(5), MCA, will not be reviewed comparatively with a proposal for which a letter of intent is filed after the 30-day deadline referred to in 50-5-302(5), MCA. (History: Sec. 2-4-201, 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-302 and 50-5-310, MCA; NEW, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1984 MAR p. 27, Eff. 1/13/84; AMD, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.108 NOTICE OF ACCEPTANCE OR EFFECTIVE WITHDRAWAL OF APPLICATION

(1) When an application is determined to be complete, the department shall issue a letter of acceptance.

(2) When an application is determined to be incomplete after the applicant has been given an opportunity to submit additional information, the department will issue the applicant a letter declaring the application is effectively withdrawn. (History: Sec. 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-302, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

Rules 09 through 11 reserved

37.106.112 INFORMATIONAL HEARING PROCEDURES

(1) Any affected person may request an informational hearing to be held during the course of the review period by writing to the department. The department may also hold a hearing on its own initiative.

(2) Whenever an application is received by the department, the department will publish a notice of that fact in a newspaper of general circulation in the area to be served by the proposal, unless the application is subject to comparative review with another, in which case the newspaper notice will be published after receipt of all of the applications to be comparatively reviewed. A hearing request must be received by the department within 30 calendar days after the date the newspaper notice is published.
(3) Notice of the informational hearing will be given at least 14 calendar days before the hearing date by the following means:
(a) Written notice must be sent by mail to the person requesting the hearing, the applicant, and all other applicants assigned for comparative review with the applicant, if any. Other persons who have requested notice will be notified by mail.
(b) Notice to all other affected persons will be by legal advertisement in a newspaper with general circulation in the service area affected by the application.
(c) The notice must indicate:
(i) the date of the hearing;
(ii) the time of the hearing;
(iii) the location of the hearing; and
(iv) the person to whom written comments may be sent prior to the hearing.
(4) Whenever a hearing is held for an application which is being comparatively reviewed with another application, the hearing will be conducted as a joint hearing on all such applications.
(5) Any person may comment during the hearing, and all comments made at the hearing will be tape-recorded and retained by the department until the project is completed or the certificate of need expires.
(6) The hearing will be informal, and neither the Montana Administrative Procedure Act nor the Rules of Civil Procedure will apply.
(7) Any person wishing to make a factual allegation at the hearing must first swear or affirm that his testimony is true.
(8) No person other than the department may conduct reasonable questioning of any person who makes relevant factual allegations. (History: Sec. 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-302, MCA; NEW, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.113 CRITERIA AND FINDINGS

(1) The criteria listed in (a) through (k) below are statutory criteria required by 50-5-304, MCA, and will be considered by the department in making its decision:
(a) the degree to which the proposal being reviewed:
(i) demonstrates that the service is needed by them population within the service area defined in the proposal;
(ii) provides data that demonstrates the need for services contrary to the current state health plan, including but not limited to waiting lists, projected service volumes, differences in cost and quality of services, and availability of services; or
(iii) is consistent with the current state health plan.
(b) the need that the population served or to be served by the proposal has for the services;

(c) the availability of less costly quality-equivalent or more effective alternative methods of providing the services;
(d) the immediate and long-term financial feasibility of the proposal as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the health service;
(e) the relationship and financial impact of the services proposed to be provided to the existing health care system of the area in which such services are proposed to be provided;
(f) the consistency of the proposal with joint planning efforts by health care providers in the area;
(g) the availability of resources, including health manpower, management personnel, and funds for capital and operating needs, for the provision of services proposed to be provided and the availability of alternative uses of the resources for the provision of other health services;
(h) the relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services;
(i) in the case of a construction project, the costs and methods of the proposed construction, including the costs and methods of energy provision, and the probable impact of the construction project reviewed on the costs of providing health services by the person proposing the construction project;
(j) the distance, convenience, cost of transportation, and accessibility of health services for persons who live outside urban areas in relation to the proposal; and
(k) in the case of a project to add long-term care facility beds:
(i) the need for the beds that takes into account the current and projected occupancy of long-term care beds in the community;
(ii) the current and projected population over 65 years of age in the community; and
(iii) other appropriate factors.
(2) In addition to the statutory criteria cited in (1) above, the department will consider the following in making its decision:
(a) the equal access the medically underserved population, as well as all other people within the geographical area documented as served by the applicant, will have to the subject matter of the proposal;
(b) whether patients will experience problems including, but not limited to, cost, availability, or accessibility in obtaining care of the type proposed in the absence of the proposed new service. (History: Sec. 50-5-103 and 50-5-304, MCA; IMP, Sec. 50-5-304, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1988 MAR p. 2484, Eff. 11/24/88; AMD, 1994 MAR p. 1296, Eff. 5/13/94; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.) 37-25916 3/31/02

37.106.114 DEPARTMENT DECISION

(1) If the department fails to reach and issue a decision within the deadlines established by 50-5-302, MCA, a certificate of need will not automatically issue unless the delay is due to an abuse of discretion by the department and the applicant obtains a writ of mandamus ordering the department to issue the certificate.

(2) If the certificate of need is issued with conditions, the conditions must be directly related to the project under review, and to the criteria listed in 50-5-304, MCA, and ARM 37.106.113, and cannot increase the scope of the project.
(3) The basis for the decision of the department must be expressed in written findings of fact and conclusions of law, which must be sent via certified mail to the applicant and all other applicants assigned for comparative review with the applicant, along with a notice of the right to a reconsideration hearing pursuant to 50-5-306, MCA, and the deadline for requesting such a hearing. The findings, conclusions, and notice will be made available, upon request, to others for cost.
(4) Notice, in summary form, of the department's decision, the right to request a reconsideration hearing, and the deadline for such a request will also be sent to each health care facility of the type affected by the application or applications in question within the geographic area affected by the application(s). (History: Sec. 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-302 and 50-5-304, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.115 APPEAL PROCEDURES

(1) Any affected person who requests a hearing to reconsider the department's decision must submit a check for $500 to the department along with the request. No hearing will be scheduled or held unless the department has received the fee.
(2) Immediately after receipt of a request for a hearing, a copy of the request will be sent to all affected persons, as defined in 50-5-101, MCA, who participated in any informational hearing that was held concerning the affected proposal.
(3) Notice of the date and time of a reconsideration hearing will be sent to the affected person requesting the hearing and, if the applicant did not request the hearing, the applicant as well.
(4) If a hearing to reconsider a decision is requested, any affected person, other than the requestor of the hearing, who wishes to participate in the hearing must, at least two weeks after the date the request for hearing is received, submit a written notice of intent to participate to the department along with a check for $500, unless the affected person is an applicant whose proposal was approved and is the subject of the hearing, in which case only the notice of intent must be received by the department.
(5) The fees required by (1) and (4) above must be paid by check made out to the department of public health and human services.
(6) Counsel for the department and the health planning staff may participate in the hearing to provide testimony and exhibits, and to cross-examine witnesses, but are not considered parties for the purposes of 2-4-613, MCA.
(7) A copy of any pre-hearing motion filed by an affected person must be served by mail upon the department and any other affected person participating in the hearing.
(8) The department's hearing officer may require the direct testimony of the witnesses of each affected person participating in the hearing to be in writing and filed prior to hearing with the department, with copies served upon the department and every other participating affected person.

(9) At the reconsideration hearing, the parties or their counsel will be given the opportunity to present written or oral evidence or statements concerning the department's action and the grounds upon which it was based.
(10) The department shall send the written findings of fact and conclusions of law that state the basis for its decision to all parties participating in the hearing. Any other person upon request may receive a copy for cost.
(11) The decision of the department following the reconsideration hearing shall be considered the department's final decision for the purpose of appealing the decision to district court.
(12) The hearing, any discovery, and other related matters are subject to the Montana Administrative Procedure Act, Title 2, chapter 4, part 6, MCA, and ARM 1.3.215 through 1.3.225 and ARM 1.3.230 through 1.3.233.
(13) The department hereby adopts and incorporates by reference ARM 1.3.215 through 1.3.225 and ARM 1.3.230 through 1.3.233, which contain attorney general's model rules for contested cases, implementing the Montana Administrative Procedure Act. Copies of the rules may be obtained from the Department of Public Health and Human Services, Office of Legal Affairs, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951, phone: (406)444-9503. (History: Sec. 50-5-103 and 50-5-306, MCA; IMP, Sec. 50-5-306 and 50-5-310, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

Rules 16 through 19 reserved

37.106.120 DURATION OF CERTIFICATE: TERMINATION; EXTENSION

(1) The department may, after notice and opportunity for a hearing, suspend or revoke a certificate of need upon a finding that the holder of the certificate is in violation of the certificate of need law, this chapter, or the terms of the certificate of need. The notice and hearing provisions of the Montana Administrative Procedure Act (Title 2, chapter 4, part 6, MCA) will apply.
(2)(a) A holder of a certificate of need may submit to the department a written request for a 6-month extension of his certificate of need, for good cause. The request must set forth the reasons constituting good cause for the extension and must be received by the department by 5:00 p.m. on the expiration date if it is to be considered.
(b) Within 20 days after receipt of the request, the department must issue its written decision granting or denying the extension. The decision must be sent to the applicant by certified mail, and distributed at cost to others who request it.
(c) Reconsideration of the department's decision may be requested by the holder and will be granted if the requester:
(i) presents significant relevant information not previously considered by the department; or
(ii) demonstrates that there have been significant changes in factors or circumstances relied upon by the department in reaching its decision.
(d) "Good cause" for the purpose of (2)(a) includes, but is not limited to, emergency situations which prevent the recipient of the certificate of need from obtaining necessary financing, commencing construction, or implementing a new service.

(3) A certificate of need, once granted to an applicant, may not be transferred to another person. In addition to a transfer from one person to another, such a transfer will be considered to have taken place if the applicant to which the certificate was granted is an organization and there is a change of ownership of 50% or more of that organization. (History: Sec. 50-5-103, 50-5-302 and 50-5-305, MCA; IMP, Sec. 50-5-302 and 50-5-305, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1983 MAR p. 732, Eff. 7/1/83; AMD, 1985 MAR p. 602, Eff. 5/31/85; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.121 INCREASE IN CERTIFIED COST

(1) The recipient of a certificate of need shall report to the department any increase in the cost of an approved project in excess of $150,000 or 15% of the approved budget for the project, whichever is greater. Any cost increase that exceeds the foregoing threshold must be approved by the department. (History: Sec. 50-5-302, MCA; IMP, Sec. 50-5-106 and 50-5-301, MCA; NEW, 1979 MAR p. 1670, Eff. 12/28/79; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

Rules 22 through 25 reserved

NEXT PAGE IS 37-25933

37.106.126 SWING BEDS: REVIEW CRITERIA

(1) A certificate of need may be issued to a hospital or medical assistance facility to establish swing beds only if, in addition to compliance with all other applicable provisions of 50-5-304, MCA, and ARM 37.106.113:

(a) existing licensed long-term care facilities in the service area, which provide the level of care proposed to be provided by the hospital or medical assistance facility, have an aggregate average occupancy level of at least 95% during the three years prior to the date of the application for certificatem of need; and

(b) no more than 50% of the excess bed capacity of the hospital or medical assistance facility will be approved as swing beds. Excess bed capacity is the difference between the number of licensed beds in the facility and the average acute care occupancy level of the facility over the three years prior to the date of the application for certificate of need.

(2) The utilization of swing beds by a medical assistance facility is subject to certificate of need review only if, as required by 50-5-301(1)(c), MCA, the facility did not offer long-term care during the 12 months prior to the month the service is scheduled to commence and the service will add annual operating and amortization expenses of $150,000 or more. (History: Sec. 50-5-304, MCA; IMP, Sec. 50-5-304, MCA; NEW, 1986 MAR p. 38, Eff. 1/17/86; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

Rules 27 through 32 reserved

37.106.133 CERTIFICATE OF NEED APPLICATION: INTRODUCTION AND COVER LETTER

(1) It is suggested that the applicant contact the health planning program before completing and submitting the necessary information. If an early contact is made, the applicant will be made aware of what will be required in specific cases before a formal application is completed and submitted.

(2) The applicant must send a cover letter, containing the information included in the original letter of intent with any pertinent revisions, to the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, P.O. Box

202953, Helena, MT 59620-2953. The cover letter must accompany the original and each of the six copies of the information required by ARM 37.106.134. (History: Sec. 2-4-201 and 50-5-302, MCA; IMP, Sec. 50-5-302, MCA; NEW, 1984 MAR p. 27, Eff. 1/13/84; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.134 CERTIFICATE OF NEED APPLICATION: REQUIRED INFORMATION

The following must be included in a certificate of need application:

(1) An explanation of the need for the facility or service, including the following information:

(a) the geographic area the proposed project will serve and the criteria being used for determining this service area;

(b) the current population of that service area (identify the source of information);

(c) the five-year projected population of that service area (identify the source of information);

(d) the percent of the population in that service area expected to be served;

(e) in terms of age, ethnic background and economic status, a description of the specific population which will be served by the proposed new institution or service. The applicant shall indicate the number of people matching this description in the service area (general public should be indicated if the facility is for non-specific population);

(f) an explanation of current and projected future trends in health care which might affect facility usage which were given consideration in the development of this project (identify source of information);

(g) a patient origin study for the last three years of operation;

(h) why the service or institution is needed in the identified service area;

(i) the purposes and goals of the project;

(j) whether there is a waiting list of persons desiring the proposed services. If so, a copy of the list must be provided.

(2) A description of the project's accessibility to the public. In particular, the following information must be included:

(a) the location of the proposed facility;

(b) the manner in which the architectural plan promotes access for the physically handicapped;

(c) other health care institutions which serve this area or portions thereof and provide similar services to those proposed in this application;

(d) if there are no similar services in the area, the nearest facility or facilities providing these services must be identified.

(3) A discussion of planning and environmentalconsiderations, including the following information:

(a) an explanation of how the proposed service or facility is compatible with the current state health plan (a copy of which may be obtained from the Department of Public Health and Human Services, Health Policy Services Division, Health Systems Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951). If it is not compatible, an explanation of why it should be approved must be included;

(b) whether a short, long-range, master plan or capital expenditure plan is available for the facility. If so, a copy must be provided. The applicant shall also provide applicable city, county or regional land use, zoning, transportation, utilities or parking plans;
(c) a description of existing or proposed working relationships or joint planning efforts with other providers or services in the community or service area. If there are no such efforts, an explanation must be provided;
(d) whether the affected consumer/provider and related groups in the service area have indicated support for the proposal (agencies, groups, and their reactions must be listed);
(e) a discussion of environmental considerations, including architectural compatibility, waste disposal, traffic impacts, economic and social impacts on the area, etc.
(4) A discussion of the organizational aspects of the project, including the following information:
(a) the type of organization or entity responsible for the day-to-day operation of the facility (e.g., state, county, city, federal, hospital district, church related, nonprofit corporation, individual, partnership, business corporation);
(b) whether the controlling organization leases the physical plant from another organization. If so, the name and type of organization that owns the plant;
(c) any changes in the ownership of the applicant duringm the past year;
(d) the name and title of the chief administrator of the applicant's facility, and whether employed by the applicant or another organization as identified in (e) below;
(e) if the controlling organization has placed responsibility for the administration of the facility with another organization, the name and type of organization that manages the facility;
(f) if the facility is operated as a part of a multifacility system (e.g., medical center, chain of hospitals owned by a religious order, etc.) the name and address of the parent organization;
(g) whether the applicant's facility has received or intends to apply for state licensure or federal certification.
(5) A discussion of the program staffing and operational capabilities of the project, including the following information:
(a) an itemized list of full-time-equivalent staff positions (current and after completion of project), and estimated number of personnel available, including:
(i) administration;
(ii) physician services;
(iii) nursing services;
(iv) social services;
(v) other professional/technical;
(vi) all other (specify);
(b) if the applicant operates an existing facility, whether it meets current staffing standards.
(6) A discussion of the physical structure and services to be provided, including the following information:
(a) a narrative description of the project, including:
(i) size, type construction, floor space to be added or renovated, beds, square feet per bed, parking, etc.;
(ii) description of both old and new facilities where applicable;

(iii) time frame(s) for construction;
(iv) a line drawing of proposal;
(b) a discussion of legal considerations, including:
(i) whether the project will correct non-conforming conditions;
(ii) whether the project is in conformance with current local zoning laws (city or county);
(iii) whether the structures meet current safety and building codes;
(c) a listing of current licensed beds, certified medicare or medicaid beds, and beds to be added in each of the basic service categories;
(d) for home health agencies, the current and proposed number of patient visits and consultations, and the reporting period;
(e) in order to show utilization levels, indication of each of the following for the applicant's facility, if already in existence, and for every other facility of the same kind within the same service area, for each of the past full three years and the current year, as well as utilization projections for each of the foregoing facilities for one, two, and three years:
(i) average daily census;
(ii) percent occupancy;
(iii) average length of stay;
(iv) total discharges;
(v) outpatient visits;
(vi) home care visits;
(vii) surgical procedures, inpatient and outpatient.
(f) If the applicant's facility is not yet in existence, the applicant must submit all of the above for any other parallel facility in the same service area, along with projections for (i) through (vii) above for the first, second, and third years of operation of the proposed facility.
(7) A discussion of capital expenditure requirements, including the following information:
(a) the approximate date that obligation of funds will be incurred for the proposal;
(b)(i) the source of funds (specify cash on hand, commercial or government loans, grants, net earnings and reserve, bequests and endorsements, charitable fund raising, revenue bonds, other);
(ii) amount available;
(iii) amount to be borrowed;
(c) term and interest rate of loan;
(d) copies of the complete financial operating statements for the last three years and, if available, audited statements;
(e) copies of the following:
(i) projected revenue and expense statements with supportive population and utilization assumptions both during construction and the first two years of operation;
(ii) utilization projections demonstrating need for the project.
(8) Estimated project costs for each of the following:
(a) consultant, legal, architect, engineering, and construction supervision;
(b) financing fees;
(c) feasibility study (include a copy);
(d) interest, principle to be borrowed, reserves related to public bond issue;

(e) land acquisition, site development, and construction.
(9)(a) Effect of project on costs and charges for room rates or specific services;
(b) discussion of operating fund demands and budget factors, including the following:
(i) the sources of operating revenue in percentages (specify medicare, medicaid, private pay, or insurance);
(ii) if grant support is provided for the project, how the service will be financed upon termination of this support;
(iii) whether depreciation will be funded;
(iv) explanation of plans for meeting possible operating deficits;
(c) effect the proposed capital expenditure will have on annual operating costs. Whether the operating costs will be increased or decreased and by how much;
(10) A discussion of cost containment factors, including the following information:
(a) how the proposal demonstrates superior community costbenefit or community cost-effectiveness;
(b) description of shared services which are available as an alternative to duplication (explain in detail);
(c) alternatives which have been considered to provide the service proposed by the project.
(11) A discussion specifically addressing the review criteria listed in 50-5-304, MCA and ARM 37.106.113.
(12) The signature of a responsible representative of the applicant, the title of the signatory, and the date of signing. (History: Sec. 2-4-201 and 50-5-302, MCA; IMP, Sec. 50-5-302, MCA; NEW, 1984 MAR p. 27, Eff. 1/13/84; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)
Rules 35 and 36 reserved
37.106.137 ANNUAL OPERATIONAL REPORTS BY HOSPITALS
(1) Every hospital shall submit an annual report to the department on a form provided by the department and no later than the deadline specified on the form. The annual reports must be signed by the hospital administrator and must include whichever of the following information is requested on the form:
(a) whether the hospital has received JCAH accreditation, and if so, for what period;
(b) beginning and ending dates of the hospital's reporting period, and whether the facility has been in operation for 12 full months at the end of the most recent reporting period;
(c) a discussion of the organizational aspects of the facility, including the following information:
(i) the type of organization or entity responsible for the day-to-day operation of the hospital (e.g., state, county, city, federal, hospital district, church related, nonprofit corporation, individual, partnership, business corporation);
(ii) whether the controlling organization leases the physical plant from another organization, and if so, the name and type of organization that owns the plant;
(iii) any changes in the ownership, board of directors or articles of incorporation during the past year;
(iv) the name of the current chairman of the board of directors;

(v) if the controlling organization has placed responsibility for the administration of the hospital with another organization, the name and type of organization that manages the facility. A copy of the latest management agreement must be provided;
(vi) if the hospital is operated as a part of a multifacility system (e.g., medical center, chain of hospitals owned by a religious order, etc.) the name and address of the parent organization;
(d) whether the hospital provides primarily general medical/surgical services, or specialty services (specify);
(e) specific facilities and services provided by the hospital, bed capacities for each service (where applicable), and whether such services are provided full or part-time, by hospital personnel, or by contracting providers;
(f) newborn nursery statistics, including:
(i) number of bassinets set up and staffed;
(ii) total number of births;
(iii) total new born days;
(iv) neonatal intensive care admissions and inpatient days;
(g) surgery statistics, including:
(i) number of inpatient and outpatient surgery suites;
(ii) number of inpatient and outpatient operations performed;
(iii) number of adult and pediatric open-heart surgical operations performed;
(iv) total adult and pediatric cardiac catheterization and intracardiac and/or coronary artery procedures;
(h) number of beds set up and staffed and total inpatient days (excluding newborns) in each basic inpatient service category;
(i) inpatient statistics, including:
(i) number of licensed hospital beds (excluding bassinets and long-term care beds);
(ii) number of admissions (excluding newborns);
(iii) number of discharges (including deaths);
(iv) number of deaths (excluding fetal deaths);
(v) census on last day of reporting period (excluding newborns);
(j) information on other services, including number of rooms or units, number of inpatient and outpatient procedures, and number of outpatient visits in at least the following areas:
(i) emergency room;
(ii) organized outpatient department;
(iii) x-ray, ultrasound, nuclear medicine, cobalt therapy, CT scans;
(iv) physical therapy;
(v) respiratory therapy;
(vi) renal dialysis;
(vii) other ancillary services;
(k) information on changes in total number of beds during the reporting period;
(l) whether there is a separate long-term care unit, and if so, how many beds;
(m) patient origin data, including every town of origin and number of discharges;
(n) total medicare and medicaid admissions and inpatient days;

(o) size of medical and non-medical staff, including number of active and consulting physicians, medical residents and trainees, registered and licensed professional or vocational nurses, and all other personnel;
(p) name of person to contact in the event the department has questions concerning the information provided in the annual report. (History: Sec. 2-4-201, 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-106 and 50-5-302, MCA; NEW, 1984 MAR p. 27, Eff. 1/13/84; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.138 ANNUAL FINANCIAL REPORTS BY HOSPITALS

(1) Every hospital shall submit an annual financial report to the department on a form provided by the department and no later than the deadline specified on the form. The annual financial report must be signed by the hospital administrator and must include whichever of the following information is requested on the form:
(a) hospital revenues for both acute and long-term care units, including:
(i) gross revenue from inpatient and outpatient service;
(ii) deductions for contractual adjustments, bad debts, charity, etc.;
(iii) other operating revenue;
(iv) nonoperating revenue (such as government appropriations, mill levies, contributions, grants, etc.);
(b) hospital expenses for both acute and long-term care units, including:
(i) payroll expenses for all categories of personnel;
(ii) nonpayroll expenses, including employee benefits, professional fees, depreciation expense, interest expense, others;
(c) detail of deductions for both acute and long-term care units, including:
(i) bad debts;
(ii) contractual adjustments (specifying medicare, medicaid, blue cross or other);
(iii) charity/Hill-Burton;
(iv) other;
(d) medicaid and medicare program revenue for both acute and long-term care units;
(e) unrestricted fund assets, including dollar amounts of:
(i) current cash and short-term investments;
(ii) current receivables and other current assets;
(iii) gross plant and equipment assets; deductions for accumulated depreciation;
(iv) long-term investments;
(v) other;
(f) unrestricted fund liabilities, including dollar amounts of:
(i) current liabilities;
(ii) long-term debts;
(iii) other liabilities;
(iv) unrestricted fund balance;
(g) restricted fund balances, with identification of specific purposes for which funds are reserved, including plant replacement and expansion, and endowment funds;
(h)(i) capital expenditures made during the reporting period, including expenditures, disposals and retirements for land, building and improvements, fixed and moveable equipment, and construction in progress;

(ii) whether a permanent change in bed complement or in the number of hospital services offered will result from any capital acquisition projects begun during the reporting period (specify);
(iii) whether a certificate of need was received for any projects during the reporting period, and if so, the total capital authorization included in such approvals. (History: Sec. 2-4-201, 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-106 and 50-5-302, MCA; NEW, 1984 MAR p. 27, Eff. 1/13/84; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.139 ANNUAL REPORTS BY LONG-TERM CARE AND PERSONAL CARE FACILITIES

(1) Every long-term care and personal care facility shall submit an annual report to the department on a form provided by the department and no later than the deadline specified on the form. The annual report must be signed by the facility administrator and must include whichever of the following information is requested on the form:
(a) the facility's reporting period, and whether the facility was in operation for a full 12 months at the end of the reporting period;
(b) a discussion of the organizational aspects of the facility, including the following information:
(i) the type of organization or entity responsible for the day-to-day operation of the facility (e.g., state, county, city, federal, hospital district, church related, nonprofit corporation, individual, partnership, business corporation);
(ii) whether the controlling organization leases the physical plant from another organization. If so, the name and type of organization that owns the plant;
(iii) any changes in the ownership, board of directors or articles of incorporation of the facility during the past year;
(iv) the name of the current chairman of the board of directors of the facility;
(v) if the controlling organization has placed responsibility for the administration of the facility with another organization, the name and type of organization that manages the facility. A copy of the latest management agreement must be provided;
(vi) if the facility is operated as a part of a multifacility system (e.g., medical center, chain of hospitals owned by a religious order, etc.) the name and address of the parent organization;
(c) utilization information, including:
(i) licensed bed capacity (skilled and intermediate);
(ii) whether the facility is certified for medicare or medicaid;
(iii) number of beds currently set up and staffed;
(iv) total patient census on first day of reporting period; total admissions, discharges, patient deaths, and patient-days of service during the reporting period;
(v) patient census on last day of reporting period, broken down by sex and age categories;
(d) financial data, including:
(i) total annual operating expenses (payroll and nonpayroll);
(ii) closing date of financial statement;
(iii) sources of operating revenue, indicating percent received from medicare, medicaid, private pay, insurance, grants, contributions, and other;
(e) staff information, including number and classification of full and part-time medical personnel, as required on the survey form;

(f) patient origin data, including patients' counties of residence, and number of admissions from state institutions and from out-of-state;
(g) name of person to contact should the department have any questions regarding the information on the report. (History: Sec. 2-4-201, 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-106 and 50-5-302, MCA; NEW, 1984 MAR p. 27, Eff. 1/13/84; AMD, 1987 MAR p. 1074, Eff. 7/17/87; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

37.106.140 ANNUAL REPORTS BY HOME HEALTH AGENCIES

(1) Every home health agency shall submit an annual report to the department on a form provided by the department and no later than the deadline specified on the form. The report must be signed by the administrator of the agency and must include whichever of the following information is requested on the form:
(a) whether the agency has medicare certification, and if so, the term of such certification;
(b) the agency's reporting period, and whether the agency was in operation for a full 12 months at the end of the reporting period;
(c) a discussion of the organizational aspects of the project, including the following information:
(i) the type of organization or entity responsible for the day-to-day operation of the agency (e.g., state, county, city, federal, hospital district, church related, nonprofit corporation, individual, partnership, business corporation);
(ii) whether the home health agency is owned by the same organization that controls it. If not, the name and type of organization that owns the agency;
(iii) any changes in the ownership, board of directors or articles of incorporation of the agency during the past year;
(iv) the name of the current chairman of the board of directors of the agency;
(v) if the controlling organization has placed responsibility for the administration of the agency with another organization, the name and type of organization that manages the facility. A copy of the latest management agreement must be provided;
(vi) if the agency is operated as a part of a multifacility system (e.g., medical center, chain of hospitals owned by a religious order, etc.) the name and address of the parent organization;
(d) a listing of specific services provided by the agency, and the number of people served and number of visits made for each service;
(e) a description of the geographic area served by the agency;
(f) the number of persons served by the agency and the number of new cases acquired by the agency during the reporting period;
(g) financial data, including:
(i) payroll and non-payroll expenses;
(ii) closing date of financial statement;
(iii) sources of operating revenue, indicating percentage received from medicare, medicaid, private pay, insurance, grants, contributions, other;
(h) staff information, including number of full, part-time and contracted registered and licensed professional nurses, home health aids, student nurses, and others;
(i) the name of the person to contact should the department have questions regarding the information on the report. (History: Sec. 2-4-201, 50-5-103 and 50-5-302, MCA; IMP, Sec. 50-5-106 and 50-5-302, MCA; NEW, 1984 MAR p. 27, Eff.

1/13/84; AMD, 1996 MAR p. 1975, Eff. 7/19/96; TRANS, from DHES, 2002 MAR p. 185.)

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHAPTER 106
HEALTH CARE FACILITIES
Subchapter 3
Construction and Minimum Standards for All Health Care Facilities
Rule 37.106.301 Definitions
37.106.302 Minimum Standards of Construction for a Licensed Health Care Facility: Addition, Alteration, or New Construction: General Requirements
Rules 03 through 05 reserved
37.106.306 Submission of Plans and Specifications: New Institutional Health Service: Alteration or Addition to a Health Care Facility
Rules 07 through 09 reserved
37.106.310 Licensing: Procedure for Obtaining a License: Issuance and Renewal of a License
37.106.311 Minimum Standards for All Health Care Facilities: Food Service Establishments
37.106.312 Minimum Standards for All Health Care Facilities: Blood Bank and Transfusion Services
Rule 37.106.313 Minimum Standards for All Health Care Facilities: Communicable Disease Control
37.106.314 Minimum Standards for All Health Care Facilities: Medical Records
Rules 15 through 19 reserved
37.106.320 Minimum Standards for All Health Care Facilities: Physical Plant and Equipment Maintenance
37.106.321 Minimum Standards for All Health Care Facilities: Environmental Control
37.106.322 Minimum Standards for All Health Care Facilities: Disaster Plan
Rules 23 through 29 reserved
37.106.330 Minimum Standards for All Health Care Facilities: Written Policy and Procedure
37.106.331 Minimum Standards for All Health Care Facilities: Laundry and Bedding
Construction and Minimum Standards for All Health Care Facilities
37.106.301 DEFINITIONS
The following definitions apply in this subchapter:
(1) "Administrator" means the individual responsible for the day-to-day operation of a hospital, skilled or intermediate care facility. This individual may also be known as, but not limited to, "chief executive officer", "executive director", or "president".
(2) "Adult day care center" means a facility as defined in 50-5-101(2), MCA, but does not include day habilitation programs for the developmentally disabled and handicapped or a program offered by a church or senior citizens organization for purposes other than provision of custodial care necessary to meet daily living needs.
(3) "Communicable disease" means an illness due or suspected to be due to a specific infectious agent or its toxic products, which results from transmission of that agent or its products to a susceptible host directly or indirectly, and includes a dangerous communicable disease.

(4) "Coronary care unit" means an area within the hospital where there is a concentration of physicians, nurses, and other staff who have special skills and experience in providing care for critically ill cardiac patients.
(5) "Diagnostic" means the art, science or method of distinguishing signs or symptoms of a diseased condition.
(6) "Hospitalization" means being hospitalized or admitted to a hospital.
(7) "Hospital record" means written records of admissions, discharges, total patient days, register of operations performed and outpatients treated.
(8) "Inpatient" means a patient lodged and fed in a facility while receiving treatment.
(9) "Intensive care unit" means an area within the hospital where there is a concentration of physicians, nurses, and other staff who have specialized skills and experience in providing care for critically ill medical and surgical patients.
(10) "Manager" means the individual responsible for the day-to-day operation of a health care facility, excluding a hospital, skilled or intermediate care facility.
(11) "Medical record" means a written document which is complete, current and contains sufficient information for planning a patient's or resident's care, reviewing and evaluating care rendered, evaluating a patient's or resident's condition, and for providing a means of communication among all persons providing care.
(12) "Obstetrical service" means an area within the hospital which provides care for a maternity patient including but not limited to labor, delivery and postpartum care.
(13) "Outpatient" means a person receiving health care services and treatment at a facility without being admitted as an inpatient to the facility.
(14) "Supervise" means to oversee and direct staff by being present in the health care facility.
(History: Sec. 50-5-103, MCA; IMP, Sec. 50-5-101, 50-5-103, 50-5-104, 50-5-105, 50-5-106, 50-5-107, 50-5-108, 50-5-109, 50-5-201, 50-5-202, 50- 5-203, 50-5-204, 50-5-207, 50-5-208, 50-5-210, 50-5-211, 50-5-212, 50-5-221, 50-5-225, 50-5-226, 50-5-227, 50-5-228, 50-5-229, 50-5-230 and 50-5-231, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1984 MAR p. 973, Eff. 6/29/84; TRANS, from DHES, 2002 MAR p. 185.)

37.106.302 MINIMUM STANDARDS OF CONSTRUCTION FOR A LICENSED HEALTH CARE FACILITY: ADDITION, ALTERATION, OR NEW CONSTRUCTION: GENERAL REQUIREMENTS

(1) Except as may otherwise be provided in (2) of this rule, a health care facility and the construction of, alteration, or addition to a facility shall comply with:
(a) all standards set forth in:
(i) the 2001 Guidelines for Design and Construction of Hospitals and Health Care Facilities and NFPA 101, "Life Safety Code", 2000 edition, except that a facility already licensed under an earlier edition of the "Life Safety Code" published by the national fire protection association, is not required to comply with later editions of the "Life Safety Code". Copies of the cited editions are available at the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, P.O. Box 202953, Helena, MT, 59620-2953.
(ii) the 1992 "American National Standards Institute A117.1".
(b) the water supply system requirements of ARM 37.111.115;
(c) the sewage system requirements of ARM 37.111.116.

(2) A personal care facility, chemical dependency treatment center, or a free-standing adult day care center:
(a) must meet all applicable building and fire codes and be approved by the officer having jurisdiction to determine if the building codes are met by the facility and by the state fire marshal or his designee;
(b) meet the water and sewer system requirements in (1)(b) and (c) above.
(3) A patient or resident may not be admitted, housed, treated, or cared for in an addition or altered area until inspected and approved, or in new construction until licensed.
(4) The department hereby adopts and incorporates by reference:
(a) The 2001 Guidelines for Design and Construction of Hospital and Health Care Facilities which set forth minimum construction and equipment requirements deemed necessary by the state department of public health and human services to ensure health care facilities can be efficiently maintained and operated to furnish adequate care.
(b) NFPA 101, "Life Safety Code 2000 edition", published by the national fire protection association, which sets forth construction and operation requirements designed to protect against fire hazards.
(c) ARM 37.111.115, which sets forth requirements for construction and maintenance of water supply systems, including supplies of ice.
(d) ARM 37.111.116, which sets forth requirements for construction and maintenance of sewage systems.
(e) The 1992 "American National Standards Institute A117.1", which sets forth standards for buildings and facilities, providing accessibility and usability for physically handicapped individuals.
(f) Copies of the materials cited above are available at the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953.
(History: Sec. 50-5-103, MCA; IMP, Sec. 50-5-103, 50-5-201 and 50-5-204, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1984 MAR p. 929, Eff. 6/15/84; AMD, 1984 MAR p. 1090, Eff. 7/27/84; AMD, 1993 MAR p. 1658, Eff. 7/30/93; AMD, 1995 MAR p. 283, Eff. 2/24/95; AMD, 1997 MAR p. 1993, Eff. 11/4/97; AMD, 2001 MAR p. 1105, Eff. 6/21/01; TRANS & AMD, 2002 MAR p. 192, Eff. 2/1/02; AMD, 2003 MAR p. 1321, Eff. 7/1/03.)
Rules 03 through 05 reserved
37.106.306 SUBMISSION OF PLANS AND SPECIFICATIONS: A NEW INSTITUTIONAL HEALTH SERVICE: ALTERATION OR ADDITION TO A HEALTH CARE FACILITY
(1) A person who contemplates construction of a new institutional health service and has been issued a certificate of need pursuant to Title 50, chapter 5, part 3, MCA, and ARM Title 37, chapter 106, subchapter 1 shall submit plans and specifications to the department for preliminary inspection and approval prior to commencing construction and shall comply with the following procedures.
(a) At least nine months prior to the time a person commences construction, he shall submit a program and schematic plans to the department. This is a maximum time limit. A person may submit a program and schematic plans as soon as he desires after he receives a certificate of need.
(i) The program must include the following:

(A) a narrative description of the rooms or spaces to be included in each department, explaining the functions or services to be provided in each, indicating the size, the number of personnel and the kind of equipment or furniture it will contain;
(B) for inpatient facilities, a schedule showing total number of beds and number of bedrooms.
(ii) The schematic plans must include the following:
(A) single line drawings of each floor which must show the relationship of the various departments or services to each other and the room arrangement in each department. The name of each room must be noted;
(B) the proposed roads and walks, service and entrance courts, and parking must be shown on the plot plan;
(C) total floor area and number of beds must be noted on the plans.
(b) At least three months prior to the time a person commences construction, he shall submit working drawings and specifications to the department. This is a maximum time limit. A person may submit working drawings and specifications as soon as he desires after the department has approved his program and schematic plans.
(i) The working drawings must be complete and adequate for bid, contract and construction purposes and must be prepared for each of the following branches of the work: architectural, structural, mechanical and electrical.
(A) Architectural drawings must include a plot plan showing all new topography, newly established levels and grades, any existing structures on the site, new buildings and structures, roadways, walks and the extent of the areas to be seeded. Any structures and improvements which are to be removed as part of the work must be shown. A print of the site survey drawing must be included with the working drawings. The architectural drawings must also include the following:
(I) plan of each basement, floor and roof;
(II) elevations of each facade;
(III) sections through building;
(IV) required scale and full-size details;
(V) schedule of doors and finishes;
(VI) location of all fixed equipment;
(VII) adequate details of any conveying system.
(B) Structural drawings must include plans for foundations, floors, roofs and all intermediate levels with sizes, sections and the relative location of the various structural members.
(C) Mechanical drawings must include plans for plumbing, heating, ventilation, air conditioning, and refrigeration.
(D) Electrical drawings must include the complete power and lighting layout of all electrical systems to be included in the construction and must include telephone layouts, nurse call system, fire alarm system and the emergency electrical system.
(c) Specifications must supplement the working drawings to fully describe types, sizes, capacities, workmanship, finishes and other characteristics of all materials and equipment.
(d) All plans and specifications must be certified by an engineer or architect licensed to practice in Montana and the certification must state that the plans and specifications are prepared in accordance with the requirements of this subchapter.

(2) A person who contemplates an alteration or addition to a health care facility which does not qualify as a new institutional health service shall submit plans to the department for preliminary inspection and approval prior to commencing construction and shall comply with the following procedures.
(a) A person who contemplates an addition to an existing health care facility shall comply with the requirements set forth in (1) of this rule.
(b) If an alteration to a health care facility is contemplated, a program and schematic plans shall be submitted to the department at least six months prior to commencing construction of the alteration. Within 30 days after this submittal, the department may request a person to comply with the requirements set forth in ARM 37.106.306(1)(b).
(c) The department's approval of an alteration or addition shall terminate one year after issuance.
(History: Sec. 50-5- 103, MCA; IMP, Sec. 50-5-103, 50-5-201 and 50-5-204, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)
Rules 07 through 09 reserved
37.106.310 LICENSING: PROCEDURE FOR OBTAINING A LICENSE: ISSUANCE AND RENEWAL OF A LICENSE
(1) A person shall comply with the following procedures when applying to the department for a license:
(a) A person shall submit a completed license application form to the department, at least 30 days prior to the opening of a facility and annually thereafter. A person can obtain a license application form from the department.
(b) A completed license application form must contain the following information:
(i) the name and address of the applicant if an individual; the name and address of each member of a firm, partnership, or association; or the name and address of each officer if a corporation;
(ii) the location of the facility;
(iii) the name of the person or persons who will administer, manage or supervise the facility;
(iv) the number and type of patients or residents for which care is provided;
(v) the number of employees in all job classifications;
(vi) a copy of the contract, lease agreement or other document indicating the person legally responsible for the operation of the health care facility if the health care facility is operated by a person other than the owner; and
(vii) designated name of health care facility to be licensed.
(A) The designated name of the health care facility may not be changed without first notifying the department in writing.
(c) Each application form must be accompanied by the applicable license fee:
(i) $20 license fee for a health care facility with 20 beds or less;
(ii) $1 per bed for a health care facility with 21 beds or more.
(d) The owner or operator of a health care facility shall sign the completed license application form.
(2) On receipt of a new or renewal license application, the department or its authorized agent shall inspect the health care facility to determine if the proposed staff is qualified

and the facility meets the minimum standards set forth in this subchapter. If minimum standards are met and the proposed staff is qualified, the department shall issue a license for one year.

(a) A patient or resident may not be admitted or cared for in a health care facility unless the facility is licensed.

(b) Licensed premises must be open to inspection by the department or its authorized agent and access to all records must be granted to the department at all reasonable times.

(c) The department may issue a provisional license for a period less than one year if continued operation of the health care facility will not result in undue hazard to patients or residents or if demand for the accommodations offered is not met in the community.

(History: Sec. 50-5-103, MCA; IMP, Sec. 50- 5-103, 50-5-202, 50-5-203 and 50-5-204, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)

37.106.311 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: FOOD SERVICE ESTABLISHMENTS

(1) A health care facility which serves food or beverage to patients or residents shall comply with the food service establishment act, Title 50, chapter 50, MCA, and food service establishments rules, ARM Title 37, chapter 110, subchapter 2.

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)

37.106.312 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: BLOOD BANK AND TRANSFUSION SERVICES (REPEALED)

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1984 MAR p. 973, Eff. 6/29/84; TRANS, from DHES, 2002 MAR p. 185; REP, 2005 MAR p. 268, Eff. 2/11/05.)

37.106.313 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: COMMUNICABLE DISEASE CONTROL

(1) All health care facilities shall develop and implement an infection prevention and control program. At minimum the facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control which must include, but not be limited to, procedures to identify high risk individuals and what methods are used to protect, contain or minimize the risk to patients, residents, staff and visitors.

(2) The administrator, or designee, shall be responsible for the direction, provision, and quality of infection prevention and control services.

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185; AMD, 2004 MAR p. 582, Eff. 3/12/04.)

37.106.314 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: MEDICAL RECORDS

(1) A health care facility shall initiate and maintain by storing in a safe manner and in a safe location a medical record for each patient and resident.

(2) A health care facility, excluding a hospital, shall retain a patient's or resident's medical records for no less than five years following the date of the patient's or resident's discharge or death.
(3) A medical record may be microfilmed or preserved via any other electronic medium that yields a true copy of the record if the health care facility has the equipment to reproduce records on the premises.
(4) A signature of a physician may not be stamped on a medical record unless there is a statement in the facility administrator's or manager's file signed by the physician stating that the physician is responsible for the content of any document signed with his rubber stamp.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-106, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1990 MAR p. 1259, Eff. 6/29/90; TRANS, from DHES, 2002 MAR p. 185.)
Rules 15 through 19 reserved
37.106.320 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: PHYSICAL PLANT AND EQUIPMENT MAINTENANCE
(1) Each facility shall have a written maintenance program describing the procedures that must be utilized by maintenance personnel to keep the building and equipment in repair and free from hazards.
(2) A health care facility shall provide housekeeping services on a daily basis.
(3) All electrical, mechanical, plumbing, fire protection, heating, and sewage disposal systems must be kept in operational condition.
(4) Floors must be covered with an easily cleanable covering; e.g., resilient flooring or ceramic tile. This covering must be cleaned daily.
(5) Carpets are prohibited in bathrooms, kitchens, laundries, or janitor closets.
(6) Walls and ceilings must be kept in good repair and be of a finish that can be easily cleaned.
(7) Every facility must be kept clean and free of odors. Deodorants may not be used for odor control in lieu of proper ventilation.
(8) The temperature of hot water supplied to handwashing and bathing facilities must not exceed 120°F.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50- 5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1984 MAR p. 973, Eff. 6/29/84; TRANS, from DHES, 2002 MAR p. 185.)
37.106.321 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: ENVIRONMENTAL CONTROL
(1) A health care facility must be constructed and maintained so as to prevent entrance and harborage of rats, mice, insects, flies, or other vermin.
(2) Hand cleansing soap or detergent and individual towels must be available at each lavatory in the facility. A waste receptacle must be located near each lavatory.
(3) A health care facility shall develop and follow a written infection control surveillance program describing the procedures that must be utilized by the entire facility staff in the identification, investigation, and mitigation of infections acquired in the facility.
(4) Cleaners used in cleaning bathtubs, showers, lavatories, urinals, toilet bowls, toilet seats, and floors must contain fungicides or germicides with current EPA registration for that purpose.

(5) Cleaning devices used for lavatories, toilet bowls, showers, or bathtubs may not be used for other purposes. Those utensils used to clean toilets or urinals must not be allowed to contact other cleaning devices.
(6) Dry dust mops and dry dust cloths may not be used for dusting or other cleaning purposes. Treated mops, wet mops, treated cloths, moist cloths or other means approved by the department which will not spread soil from one place to another must be used for dusting and cleaning and must be stored separately from the cleaning devices described in (5) above.
(7) A minimum of 10 foot-candles of light must be available in all rooms and hallways, with the following exceptions:
(a) all reading lamps must have a capacity to provide a minimum of 30 foot-candles of light;
(b) all toilet and bathing areas must be provided with a minimum of 30 foot-candles of light;
(c) general lighting in food preparation areas must be a minimum of 50 foot-candles of light;
(d) hallways must be illuminated at all times by at least a minimum of five foot-candles of light at the floor.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD,
1984 MAR p. 973, Eff. 6/29/84; TRANS, from DHES, 2002 MAR p. 185.)

37.106.322 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: DISASTER PLAN

(1) A health care facility shall develop a disaster plan in conjunction with other emergency services in the community which must include a procedure that will be followed in the event of a natural or man-caused disaster.
(2) A health care facility shall conduct a drill of such procedure at least once a year. After a drill, a health care facility shall prepare and retain on file a written report including, but not limited to, the following:
(a) date and time of the drill;
(b) the names of staff involved in the drill;
(c) the names of other health care facilities, if any, which were involved in the drill;
(d) the names of other persons involved in the drill;
(e) a description of all phases of the drill procedure and suggestions for improvement; and
(f) the signature of the person conducting the drill.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 0-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; RANS, from DHES, 2002 MAR p. 185.)

Rules 23 through 29 reserved

37.106.330 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: WRITTEN POLICY AND PROCEDURE

(1) A written policy and procedure for all services provided in a health care facility must be available to and followed by all personnel.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)

37.106.331 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: LAUNDRY AND BEDDING

(1) If a health care facility processes its laundry on the facility site, it must:

(a) set aside and utilize a room solely for laundry purposes;

(b) equip the laundry room with a mechanical washer and dryer (or additional machines if necessary to handle the laundry load), handwashing facilities, mechanical ventilation to the outside, a fresh air supply, and a hot water supply system which supplies the washer with water of at least 160°F (71°C) during each use;

(c) sort and store soiled laundry in an area separate from that used to sort and store clean laundry;

(d) provide well maintained carts or other containers impervious to moisture to transport laundry, keeping those used for soiled laundry separate from those used for clean laundry;

(e) dry all bed linen, towels, and washcloths in the dryer, or, in the case of bed linen, by use of a flatwork ironer;

(f) protect clean laundry from contamination;

(g) ensure that facility staff handling laundry cover their clothes while working with soiled laundry, use separate clean covering for their clothes while handling clean laundry, and wash their hands both after working with soiled laundry and before they handle clean laundry.

(2) If laundry is cleaned off site, the health care facility must utilize a commercial laundry (not self-service) which satisfies the requirements stated in (1)(a) through (g) above.

(3) A health care facility with beds must:

(a) keep each resident bed dressed in clean bed linen in good condition;

(b) keep a supply of clean bed linen on hand sufficient to change beds often enough to keep them clean, dry, and free from odors;

(c) supply each resident at all times with clean towels and washcloths;

(d) provide each resident bed with a moisture-proof mattress or a moisture-proof mattress cover and mattress pad;

(e) provide each resident with enough blankets to maintain warmth while sleeping.

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1984 MAR p. 973, Eff. 6/29/84; TRANS, from DHES, 2002 MAR p. 185.)

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHAPTER 106
HEALTH CARE FACILITIES
Subchapter 6
Minimum Standards for Nursing Facilities
Rule 37.106.601 Minimum Standards for a Skilled and Skilled/Intermediate Care Facility: General Requirements
Rules 02 through 04 reserved
37.106.605 Minimum Standards for a Skilled Nursing Care Facility for Each 24 Hour Period: Staffing
37.106.606 Minimum Standards for a Skilled andSkilled/Intermediate Care Facility: Drug Services
Rules 07 through 39 reserved
Rule 37.106.640 Minimum Standards for an Infirmary
Rules 41 through 44 reserved
37.106.645 Minimum Standards for an Intermediate Developmental Disability Care Facility
Rules 46 through 49 reserved
37.106.650 Minimum Standards for a Kidney Treatment Center
Minimum Standards for Nursing Facilities
37.106.601 MINIMUM STANDARDS FOR A SKILLED AND SKILLED/ INTERMEDIATE CARE FACILITY: GENERAL REQUIREMENTS
(1) A skilled nursing care facility shall comply with the Conditions of Participation for Skilled Nursing Facilities as set forth in 42 CFR 405, Subpart K. An intermediate care facility shall comply with the requirements set forth in 42 CFR 442, Subparts E and F. A copy of the cited rules is available at the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)
Rules 02 through 04 reserved
37.106.605 MINIMUM STANDARDS FOR A SKILLED NURSING CARE FACILITY FOR EACH 24 HOUR PERIOD: STAFFING
(1) The following table indicates an absolute minimum staffing pattern below which an acceptable level of care and safety cannot be maintained. Even with this staffing it would be difficult. Therefore, it is recommended that the quantity and quality of staffing should be determined by the administrator in consultation with his director of nursing. This decision should be based on the nursing needs of the patients and should reflect the current concepts of restorative and geriatric care.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; Eff. 12/31/72; TRANS, from DHES, 2002 MAR p. 185.)

INSERT TABLE FROM 37.106.605, FROM PAGE 115, STAFFING GRID

37.106.606 MINIMUM STANDARDS FOR A SKILLED AND SKILLED/ INTERMEDIATE CARE FACILITY: DRUG SERVICES

(1) Medication shall be released to a patient at discharge only on the written authorization of his licensed physician.
(2) Self-administration of medication by a patient is not permitted except on order of his licensed physician.
(3) Any deviation from the prescribed drug dosage, route or frequency of administration and unexpected drug reactions shall be reported immediately to the patient's licensed physician with an entry made on the patient's medical record and on an incident report.
(4) A current medication reference book must be provided at each nurses station.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)
Rules 07 through 39 reserved
37.106.640 MINIMUM STANDARDS FOR AN INFIRMARY
(1) Theinfirmary shall provide patients with licensed physician care.
(2) The infirmary shall provide skilled nursing services. A licensed registered nurse shall serve as charge nurse on the day shift; and a licensed registered or practical nurse shall serve as charge nurse on evening and night shifts.
(3) Nurse staffing schedules must be maintained on file in the infirmary for the preceding six months.
(4) The infirmary shall maintain a medical record for each patient which includes, but is not limited to the following information:
(a) identification data;
(b) chief complaint;
(c) present illness;
(d) medical history;
(e) physical examination;
(f) laboratory and x-ray reports;
(g) treatment administered;
(h) tissue report;
(i) progress reports;
(j) discharge summary.
(5) If a modified diet is ordered by a physician for a patient, facilities must be available for its preparation and service.
(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)
Rules 41 through 44 reserved
37.106.645 MINIMUM STANDARDS FOR AN INTERMEDIATE DEVELOPMENTAL DISABILITY CARE FACILITY
(1) An intermediate developmental disability care facility shall comply with the conditions of participation for intermediate care facilities for the mentally retarded as set forth in 42 CFR 442, Subpart G.
(2) The department hereby adopts and incorporates by reference 42 CFR 442, Subpart G, which is a federal agency rule setting forth administrative, personnel, programmatic, and health standards that must be met by any intermediate care facility for the mentally retarded in order to be medicaid eligible. A copy of 42 CFR 442, Subpart G, may be

obtained from the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953. (History: Sec. 50-5-103, MCA; IMP, Sec. 50-5-103, 50-5-201 and 50-5-204, MCA; NEW, 1984 MAR p. 973, Eff. 6/29/84; TRANS, from DHES, 2002 MAR p. 185.)

Rules 46 through 49 reserved

37.106.650 MINIMUM STANDARDS FOR A KIDNEY TREATMENT CENTER

(1) A kidney treatment center shall comply with the requirements set forth in 42 CFR 405, Subpart U.

(2) The department hereby adopts and incorporates by reference 42 CFR 405, Subpart U, which sets standards that suppliers of end-stage renal disease services must meet in order to be certified for reimbursement from the federal medicare or medicaid programs. A copy of 42 CFR 405, Subpart U, is available from the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953.

(History: Sec. 50-5-103, MCA; IMP, Sec. 50-5-103, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1994 MAR p. 3192, Eff. 12/23/94; TRANS, from DHES, 2002 MAR p. 185.)

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHAPTER 106
HEALTH CARE FACILITIES
Assisted Living Facilities
Subchapter 28

Rule 37.106.2859 Pets
37.106.2860 Food Service
37.106.2861 Laundry
37.106.2862 Housekeeping
Rules 63 and 64 reserved
37.106.2865 Physical Plant
37.106.2866 Construction, Building and Fire Codes
Rules 67 through 71 reserved
37.106.2872 Requirements for Category B Facilities Only
37.106.2873 Administrator Qualifications: Category B
37.106.2874 Direct Care Staff Qualifications: Category B
37.106.2875 Resident Health Care Plan: Category B
Rules 76 through 78 reserved
37.106.2879 Incontinence Care: Category B
37.106.2880 Prevention and Care of Pressure Sores: Category B
Rules 81 through 83 reserved
37.106.2884 Severe Cognitive Impairment: Category B
37.106.2885 Administration of Medications: Category B
37.106.2886 Medications: Records and Documentation: Category B
Rules 87 through 90 reserved
Rule 37.106.2891 Administrator Qualifications: Category C
37.106.2892 Direct Care Staff: Category C
Rules 93 and 94 reserved
37.106.2895 Health Care Plan: Category C
37.106.2896 Disclosures to Residents: Category C
Rule 97 reserved
37.106.2898 Requirements for Secured Units: Category C

37.106.2801 SCOPE

(1) The rules in this chapter pertain to facilities which provide personal care services. These rules constitute the basis for the licensure of assisted living facilities by the Montana department of public health and human services.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2802 PURPOSE

(1) The purpose of these rules is to establish standards for assisted living A, B and C facilities. Assisted living facilities are a setting for frail, elderly or disabled persons which provide supportive health and service coordination to maintain the residents' independence, individuality, privacy and dignity.

(2) An assisted living facility offers a suitable living arrangement for persons with a range of capabilities, disabilities, frailties and strengths. In general however, assisted living is not appropriate for individuals who are incapable of responding to their environment, expressing volition, interacting or demonstrating any independent activity. For example, individuals in a persistent vegetative state who require long term nursing care should not be placed or cared for in an assisted living facility.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2803 APPLICATION OF RULES

(1) Category A facilities must meet the requirements of ARM 37.106.2801 through 37.106.2871.

(2) Category B facilities must meet the requirements of ARM 37.106.2801 through 37.106.2886.

(3) Category C facilities must meet the requirements of ARM 37.106.2801 through 37.106.2886 and ARM 37.106.2891 through 37.106.2898.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2804 APPLICATION OF OTHER RULES

(1) To the extent that other licensure rules in ARM Title 37, chapter 106, subchapter 3 conflict with the terms of ARM Title 37, chapter 106, subchapter 27, the terms of subchapter 27 will apply to assisted living facilities.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2805 DEFINITIONS The following definitions apply in this subchapter:

(1) "Activities of daily living (ADLs)" means tasks usually performed in the course of a normal day in a resident's life that include eating, walking, mobility, dressing, grooming, bathing, toileting and transferring.

(2) "Administrator" means the person designated on the facility application or by written notice to the department as the person responsible for the daily operation of the facility and for the daily resident care provided in the facility.

(3) "Advance directive" means a written instruction, such as a living will, a do not resuscitate (DNR) order or durable power of attorney (POA) for health care, recognized under state law relating to the provision of health care when the individual is incapacitated.

(4) "Ambulatory" means a person is capable of self mobility, either with or without mechanical assistance. If mechanical assistance is necessary, the person is considered ambulatory only if they can, without help from another person, transfer, safely operate and utilize the mechanical assistance, exit and enter the facility and access all common living areas of the facility.

(5) "Assisted living facility" is defined at 50-5-101, MCA.

(6) "Change of ownership" means the transfer of ownership of a facility to any person or entity other than the person or entity to whom the facility's license was issued, including the transfer of ownership to an entity which is wholly owned by the person or entity to whom the facility's license was issued.

(7) "Department" means the department of public health and human services.

(8) "Direct care staff" means a person or persons who directly assist residents with personal care services and medication. It does not include housekeeping, maintenance,

dietary, laundry, administrative or clerical staff at times when they are not providing any of the above-mentioned assistance. Volunteers can be used for direct care, but may not be considered part of the required staff.

(9) "Health care plan" means a written resident specific plan identifying what ongoing assistance with activities of daily living and health care services is provided on a daily or regular basis by a licensed health care professional to a category B or C resident under the orders of the resident's practitioner. Health care plans are developed as a result of a resident assessment performed by a licensed health care professional who may consult with a multi-disciplinary team.

(10) "Health care service" means any service provided to a resident of an assisted living facility that is ordered by a practitioner and required to be provided or delegated by a licensed, registered or certified health care professional. Any other service, whether or not ordered by a physician or practitioner, that is not required to be provided by a licensed, registered, or certified health care professional is not to be considered a health care service.

(11) "Involuntary transfer or discharge" means the involuntary discharge of a resident from the licensed facility or the involuntary transfer of a resident to a bed outside of the licensed facility. The term does not include the transfer of a resident from one bed to another within the same licensed facility, or the temporary transfer or relocation of the resident outside the licensed facility for medical treatment.

(12) "License" means the document issued by the department that authorizes a person or entity to provide personal care or assisted living services.

(13) "Licensed health care professional" means a licensed physician, physician assistant-certified, advanced practice registered nurse, or registered nurse who is practicing within the scope of the license issued by the department of labor and industry.

(14) "Mechanical assistance" means the use of any assistive device that aids in the mobility and transfer of the resident. Assistive devices include but are not limited to, braces, walkers, canes, crutches, wheelchairs and similar devices.

(15) "Medication administration" means an act in which a prescribed drug or biological is given to a resident by an individual who is authorized in accordance with state laws and regulations governing such acts.

(16) "Nursing care" means the practice of nursing as governed by Title 37, chapter 8, MCA and by administrative rules adopted by the board of nursing, found at ARM Title 8, chapter 32, subchapters 1 through 17.

(17) "Personal care" means the provision of services and care for residents who need some assistance in performing the activities of daily living.

(18) "Practitioner" means an individual licensed by the department of labor and industry who has assessment, admission and prescription authority.

(19) "PRN medication" means an administration scheme, in which a medication is not routine, is taken as needed and requires the licensed health care professional or individual resident's cognitive assessment and judgement for need and effectiveness.

(20) "Resident" means anyone at least 18 years of age accepted for care in an assisted living facility.

(21) "Resident agreement" means a signed, dated, written document that lists all charges, services, refunds and move out criteria and complies with ARM 37.106.2823.

(22) "Resident certification" means written certification by a licensed health care professional that the facility can adequately meet the particular needs of a resident. The licensed health care professional making the resident certification must have:
(a) visited the resident on site; and
(b) determined that the resident's health care status does not require services at another level of care.
(23) "Resident's legal representative" or "resident's representative" means the resident's guardian, or if no guardian has been appointed, then the resident's family member or other appropriate person acting on the resident's behalf.
(24) "Self-administration assistance" means providing necessary assistance to any resident in taking their medication, including:
(a) removing medication containers from secured storage;
(b) providing verbal suggestions, prompting, reminding, gesturing or providing a written guide for self-administrating medications;
(c) handing a prefilled, labeled medication holder, labeled unit dose container, syringe or original marked, labeled container from the pharmacy or a medication organizer as described in ARM 37.106.2847 to the resident;
(d) opening the lid of the above container for the resident;
(e) guiding the hand of the resident to self-administer the medication;
(f) holding and assisting the resident in drinking fluid to assist in the swallowing of oral medications; and
(g) assisting with removal of a medication from a container for residents with a physical disability which prevents independence in the act.
(25) "Service coordination" means that the facility either directly provides or assists the resident to procure services including, but not limited to:
(a) beauty or barber shop;
(b) financial assistance or management;
(c) housekeeping;
(d) laundry;
(e) recreation activities;
(f) shopping;
(g) spiritual services; and
(h) transportation.
(26) "Service plan" means a written plan for services developed by the facility with the resident or resident's legal representative which reflects the resident's capabilities, choices and, if applicable, measurable goals and risk issues. The plan is developed on admission and is reviewed and updated annually and if there is a significant change in the resident's condition. The development of the service plan does not require a licensed health care professional.
(27) "Severe cognitive impairment" means the loss of intellectual functions, such as thinking, remembering and reasoning, of sufficient severity to interfere with a person's daily functioning. Such a person is incapable of recognizing danger, self-evacuating, summoning assistance, expressing need and/or making basic care decisions.
(28) "Significant event" means a change in health status that requires care from a licensed health care professional such as:
(a) a change in resident services;

(b) explained or unexplained injuries to the resident that require medical intervention or first aid; or
(c) resident on resident, resident on staff or staff on resident aggression.
(29) "Therapeutic diet" means a diet ordered by a physician or practitioner as part of treatment for a disease or clinical condition or to eliminate or decrease specific nutrients in the diet, (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium) or to provide food the resident is able to eat (e.g., mechanically altered diet).
(30) "Third party services" means care and services provided to a resident by individuals or entities who have no fiduciary interest in the facility.
(31) "Treatment" means a therapy, modality, product, device or other intervention used to maintain well being or to diagnose, assess, alleviate or prevent a disability, injury, illness, disease or other similar condition.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2003 MAR p. 17, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
Rules 06 through 08 reserved
37.106.2809 LICENSE APPLICATION PROCESS
(1) Application for a license accompanied by the required fee shall be made to the Department of Public Health and Human Services, Quality Assurance Division, Licensure Bureau, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953 upon forms provided by the department and shall include full and complete information as to the:
(a) identity of each officer and director of the corporation, if organized as a corporation;
(b) identity of each general partner if organized as a partnership or limited liability partnership;
(c) name of the administrator and administrator's qualifications;
(d) name, address and phone number of the management company if applicable;
(e) physical location address, mailing address and phone number of the facility;
(f) maximum number of A beds, B beds and C beds in the facility;
(g) policies and procedures as outlined in ARM 37.106.2815; and
(h) resident agreement, as outlined in ARM 37.106.2831, intended to be used.
(2) Every facility shall have distinct identification or name and shall notify the department in writing within 30 days prior to changing such identification or name.
(3) Each assisted living facility shall promptly report to the department any plans to relocate the facility at least 30 days prior to effecting such a move.
(4) In the event of a facility change of ownership, the new owners shall provide the department the following:
(a) a completed application with fee;
(b) a copy of the fire inspection conducted within the past year;
(c) policies and procedures as prescribed in ARM 37.106.2815;
(i) if applicable, a written statement indicating that the same policies and procedures will be used is required;
(d) a copy of the resident agreement as outlined in ARM 37.106.2823 to be used; and
(e) documentation of compliance with ARM 37.106.2814.

(5) Under a change of ownership, the seller shall return to the department the assisted living license under which the facility had been previously operated. This information must be sent to the Department of Public Health and Human Services, Quality Assurance Division, Licensure Bureau, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2810 LICENSE RESTRICTIONS

(1) A license is not subject to sale, assignment or other transfer, voluntary or involuntary.

(2) A license is valid only for the premises for which the original license was issued.

(3) The license remains the property of the department and shall be returned to the department upon closing or transfer of ownership.

(a) The address for returning the license is Department of Public Health and Human Services, Quality Assurance Division, Licensure Bureau, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

Rules 11 through 13 reserved

37.106.2814 ADMINISTRATOR

(1) Each assisted living facility shall employ an administrator. The administrator is responsible for operation of the assisted living facility at all times and shall ensure 24-hour supervision of the residents.

(2) The administrator must meet the following minimum requirements:

(a) be currently licensed as a nursing home administrator in Montana or another state; or

(b) has successfully completed all of the self study modules of "The Management Library for Administrators and Executive Directors", a component of the assisted living training system published by the assisted living university (ALU); or

(c) be enrolled in and complete the self study course referenced in (2)(b), within six months from hire.

(3) The administrator must show evidence of at least 16 contact hours of annual continuing education relevant to the individual's duties and responsibilities as administrator of the assisted living facility.

(a) A nursing home administrator license or the ALU certification count as 16 hours of annual continuing education but only for the calendar year in which the license or certification was initially obtained.

(4) In the absence of the administrator, a staff member must be designated to oversee the operation of the facility during the administrator's absence. The administrator or designee shall be in charge, on call and physically available on a daily basis as needed, and shall ensure there are sufficient, qualified staff so that the care, well being, health and safety needs of the residents are met at all times.

(a) If the administrator will be absent from the facility for more than 30 continuous days, the department shall be given written notice of the individual who has been appointed the designee. The appointed designee must meet all the requirements of ARM 37.106.2814(1) and (2).

(5) The administrator or designee may not be a resident of the facility.
(a) A designee must:
(i) be age 18 or older; and
(ii) have demonstrated competencies required to assure protection of the safety and physical, mental and emotional health of residents.
(6) The administrator or their designee shall:
(a) ensure that current facility licenses are posted at a place in the facility that is accessible to the public at all times;
(b) oversee the day-to-day operation of the facility including but not limited to:
(i) all personal care services to residents;
(ii) the employment, training and supervision of staff and volunteers;
(iii) maintenance of buildings and grounds; and
(iv) record keeping; and
(c) protect the safety and physical, mental and emotional health of residents.
(7) The facility shall notify the department within five days of an administrator's departure or a new administrator's employment.
(8) The administrator or designee shall initiate transfer of a resident through the resident and/or the resident's practitioner, appropriate agencies or the resident's legal representative when the resident's condition is not within the scope of services of the assisted living facility.
(9) The administrator or designee shall accept and retain only those residents whose needs can be met by the facility and who meet the acceptance criteria found in 50-5-226, MCA.
(10) The administrator or designee must ensure that a resident who is ambulatory only with mechanical assistance is:
(a) able to safely self-evacuate the facility without the aid of an elevator or similar mechanical lift;
(b) have the ability to move past a building code approved occupancy barrier or smoke barrier into an adjacent wing or building section; or
(c) reach and enter an approved area of refuge.
(11) The administrator or designee shall ensure and document that orientation is provided to all employees at a level appropriate to the employee's job responsibilities.
(12) The administrator or designee shall review every accident or incident causing injury to a resident and document the appropriate corrective action taken to avoid a reoccurrence.
(13) The owner of an assisted living facility may serve as administrator, or in any staff capacity, if the owner meets the qualifications specified in these rules.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2815 WRITTEN POLICIES AND PROCEDURES

(1) A policy and procedure manual for the organization and operation of the assisted living facility shall be developed, implemented, kept current and reviewed as necessary to assure the continuity of care and day to day operations of the facility. Each review of the manual shall be documented, and the manual shall be available in the facility to staff,

residents, residents' legal representatives and representatives of the department at all times.
(2) The manual must include an organizational chart delineating the lines of authority, responsibility and accountability for the administration and resident care services of the facility.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2003 MAR p. 17, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2816 ASSISTED LIVING FACILITY STAFFING

(1) The administrator shall develop minimum qualifications for the hiring of direct care staff and support staff.
(2) The administrator shall develop policies and procedures for screening, hiring and assessing staff which include practices that assist the employer in identifying employees that may pose risk or threat to the health, safety or welfare of any resident and provide written documentation of findings and the outcome in the employee's file.
(3) New employees shall receive orientation and training in areas relevant to the employee's duties and responsibilities, including:
(a) an overview of the facility's policies and procedures manual in areas relevant to the employee's job responsibilities;
(b) a review of the employee's job description;
(c) services provided by the facility;
(d) the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act found at 52-3-801, MCA; and
(e) the Montana Long-Term Care Resident Bill of Rights Act found at 50-5-1101, MCA.
(4) In addition to meeting the requirements of (3), direct care staff shall be trained to perform the services established in each resident service plan.
(5) Direct care staff shall be trained in the use of the abdominal thrust maneuver and basic first aid. If the facility offers cardiopulmonary resuscitation (CPR), at least one personm per shift shall hold a current CPR certificate.
(6) The following rules must be followed in staffing the assisted living facility:
(a) direct care staff shall have knowledge of the resident's needs and any events about which the employee should notify the administrator or the administrator's designated representative;
(b) the facility shall have a sufficient number of qualified staff on duty 24 hours a day to meet the scheduled and unscheduled needs of each resident, to respond in emergency situations, and all related services, including, but not limited to:
(i) maintenance of order, safety and cleanliness;
(ii) assistance with medication regimens;
(iii) preparation and service of meals;
(iv) housekeeping services and assistance with laundry; and
(v) assurance that each resident receives the supervision and care required by the service or health care plan to meet the resident's basic needs;
(c) an individual on each work shift shall have keys to all relevant resident care areas and access to all items needed to provide appropriate resident care;
(d) direct care staff may not perform any service for which they have not received appropriate documented training; and

(e) facility staff may not perform any health care service that has not been appropriately delegated under the Montana Nurse Practice Act or in the case of licensed health care professionals that is beyond the scope of their license.
(7) Employees and volunteers may perform support services, such as cooking, housekeeping, laundering, general maintenance and office work after receiving an orientation to the appropriate sections of the facility's policy and procedure manual. Any person providing direct care, however, is subject to the orientation and training requirements for direct care staff.
(8) Volunteers may be utilized in the facility, but may not be included in the facility's staffing plan in lieu of facility employees. In addition, the use of volunteers is subject to the following:
(a) volunteers must be supervised and be familiar with resident rights and the facility's policy and procedures which apply to their duties as a volunteer; and
(b) volunteers shall not assist with medication administration, delegated nursing tasks, bathing, toileting or transferring.
(9) Residents may participate voluntarily in performing household duties and other tasks suited to the individual resident's needs and abilities, but residents may not be used as substitutes for required staff or be required to perform household duties or other facility tasks.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2817 EMPLOYEE FILES

(1) The facility is responsible for maintaining a file on each employee and substitute personnel.
(2) The following documentation from employee files must be made available to the department at all reasonable times, but shall be made available to the department within 24 hours after the department requests to review the files.
(a) the employee's name;
(b) a copy of current credentials, certifications or professional licenses as required to perform the job description;
(c) an initialed copy of the employee's job description; and
(d) initialed documentation of employee orientation and ongoing training including documentation of Heimlich maneuver training, basic first aid and CPR.
(3) The facility shall keep an employee file that meets the requirements set forth in (2) for the administrator of the facility, even when the administrator is the owner.
(4) The employer must have evidence of contact to verify that each certified nursing assistant has no adverse findings entered on the nurse aid registry maintained by the department in the certification bureau.
(a) A facility may not employ or continue employment of any person who has adverse findings on the department nurse aide registry maintained by the department's certification bureau.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

Rules 18 through 20 reserved

37.106.2821 RESIDENT APPLICATION AND NEEDS ASSESSMENT

PROCEDURE
(1) All facilities must develop a written application procedure for admission to the facility which includes the prospective resident's name and address, sex, date of birth, marital status and religious affiliation (if volunteered).
(2) The facility shall determine whether a potential resident meets the facility's admission requirements and that the resident is appropriate to the facility's license endorsement as either a category A, category B or category C facility, as specified in 50-5-226(2) through (4), MCA.
(3) Prior to admission the facility shall conduct an initial resident needs assessment to determine the prospective resident's needs.
(4) The initial resident's needs assessment must include documentation of the following:
(a) cognitive patterns to include short-term memory, long term memory, memory recall, decision making change in cognitive status/awareness or thinking disorders;
(b) sensory patterns to include hearing, ability to understand others, ability to make self understood and ability to see in adequate light;
(c) activities of daily living (ADL) functional performance to include ability to transfer, locomotion, mobility devices, dressing, eating, use of toilet, bladder continence, bowel continence, continence appliance/programs, grooming and bathing;
(d) mood and behavior patterns, sadness or anxiety displayed by resident, wandering, verbally abusive, physically abusive and socially inappropriate/disruptive behavior;
(e) health problems/accidents;
(f) weight/nutritional status to include current weight and nutritional complaints;
(g) skin problems;
(h) medication use to include taking prescription and/or over-the-counter, recent changes, currently taking an antibiotic, antipsychotic use, antianxiety/hypnotic use and antidepressant use; and
(i) use of restraints, safety or assistive devices.
(5) The department shall collect a fee of $100 from a prospective resident, resident or facility appealing a rejection or relocation decision made pursuant to ARM 37.106.2821, to cover the cost of the independent nurse resident needs
assessment.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2822 RESIDENT SERVICE PLAN: CATEGORY A
(1) Based on the initial resident's needs assessment, an initial service plan shall be developed for all category A residents. The initial service plan shall be reviewed or modified within 60 days of admission to assure the service plan accurately reflects the resident's needs and preferences.
(2) The service plan shall include a written description of:
(a) what the service is;
(b) who will provide the service;
(c) when the service is performed;
(d) where and how often the service is provided;
(e) changes in service and the reasons for those changes;
(f) if applicable, the desired outcome;

(g) an emergency contact with phone number; and
(h) the prospective resident's practitioner's name, address, telephone number and whether there are any health care decision making instruments in effect if applicable.
(3) The resident's needs assessment and service plan shall be reviewed and updated annually, or any time the resident's needs change significantly.
(4) A copy of the resident service plan shall be given to the resident or resident's legal representative and be made part of the resident file.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

37.106.2823 RESIDENT AGREEMENT

(1) An assisted living facility shall enter into a written resident agreement with each prospective resident prior to admission to the assisted living facility. The agreement shall be signed and dated by a facility representative and the prospective resident or the resident's legal representative. The facility shall provide the prospective resident or the resident's legal representative and the resident's practitioner, if applicable, a copy of the agreement and shall explain the agreement to them. The agreement shall include at least the following items:
(a) the criteria for requiring transfer or discharge of the resident to another level of care;
(b) a statement explaining the availability of skilled nursing or other professional services from a third party provider to a resident in the facility;
(c) the extent that specific assistance will be provided by the facility as specified in the resident service plan;
(d) a statement explaining the resident's responsibilities including but not limited to house rules, the facility grievance policy, facility smoking policy and policies regarding pets;
(e) a listing of specific charges to be incurred for the resident's care, frequency of payment, facility rules relating to nonpayment of services and security deposits, if any are required;
(f) a statement of all charges, fines, penalties or late fees that shall be assessed against the resident;
(g) a statement that the agreed upon facility rate shall not be changed unless 30 day advance written notice is given to the resident and/or the resident's legal representative; and
(h) an explanation of the assisted living facility's policy for refunding payment in the event of the resident's absence, discharge or transfer from the facility and the facility's policy for refunding security deposits.
(2) When there are changes in services, financial arrangements, or in requirements governing the resident's conduct and care, a new resident/provider agreement must be executed or the original agreement must be updated by addendum and signed and dated by the resident or the resident's legal representative and by the facility representative.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2824 INVOLUNTARY DISCHARGE CRITERIA

(1) Residents shall be given a written 30 day notice when they are requested to move out. The administrator or designee shall initiate transfer of a resident through the resident's physician or practitioner, appropriate agencies, or the resident for

resident's legal representative when:
(a) the resident's needs exceed the level of ADL services the facility provides;
(b) the resident exhibits behavior or actions that repeatedly and substantially interfere with the rights, health, safety or well being of other residents and the facility has tried prudent and reasonable interventions;
(i) documentation of the interventions attempted by the facility shall become part of the resident's record;
(c) the resident, due to severe cognitive decline, is not able to respond to verbal instructions, recognize danger, make basic care decisions, express needs or summon assistance, except as permitted by ARM 37.106.2891 through 37.106.2898;
(d) the resident has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed in the assisted living environment;
(e) the resident has had a significant change in condition that requires medical or psychiatric treatment outside the facility and at the time the resident is to be discharged from that setting to move back into the assisted living facility, appropriate facility staff have re-evaluated the resident's needs and have determined the resident's needs exceed the facility's level of service. Temporary absence for medical treatment is not considered a move out; or
(f) the resident has failed to pay charges after reasonable and appropriate notice.
(2) The resident's 30 day written move out notice shall, at a minimum, include the following:
(a) the reason for transfer or discharge;
(b) the effective date of the transfer or discharge;
(c) the location to which the resident is to be transferred or discharged;
(d) a statement that the resident has the right to appeal the action to the department; and
(e) the name, address and telephone number of the state long term care ombudsman.
(3) A resident may be involuntarily discharged in less than 30 days for the following reasons:
(a) if a resident has a medical emergency;
(b) the resident exhibits behavior that poses an immediate danger to self or others; or
(c) if the resident has not resided in the facility for 30 days.
(4) A resident has a right to a fair hearing to contest an involuntary transfer or discharge.
(a) Involuntary transfer or discharge is defined in ARM 37.106.2805.
(b) A resident may exercise his or her right to appeal an involuntary transfer or discharge by submitting a written request for fair hearing to the Department of Public Health and Human Services, Quality Assurance Division, Office of Fair Hearings, P.O. Box 202953, 2401 Colonial Drive, Helena, MT 59620-2953, within 30 days of notice of transfer or discharge.
(c) The parties to a hearing regarding a contested transfer or discharge are the facility and the resident contesting the transfer or discharge. The department is not a party to such a proceeding, and relief may not be granted to either party against the department in a hearing regarding a contested transfer or discharge.
(d) Hearings regarding a contested transfer or discharge shall be conducted in accordance with ARM 37.5.304, 37.5.305, 37.5.307, 37.5.313, 37.5.322, 37.5.325 and 37.5.334, and a resident shall be considered a claimant for purposes of these rules.

(e) The request for appeal of a transfer or discharge does not automatically stay the decision of the facility to transfer or discharge the resident. The hearing officer may, for good cause shown, grant a resident's request to stay the facility's decision pending a hearing.
(f) The hearing officer's decision following a hearing shall be the final decision for the purposes of judicial review under ARM 37.5.334.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2003 MAR p. 17, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
Rules 25 through 27 reserved
37.106.2828 RESIDENT RIGHTS
(1) The facility shall comply with the Montana Long-Term Care Residents' Bill of Rights, found at 50-5-1101, et seq., MCA. This includes the posting of the facility's statement of resident rights in a conspicuous place. Prior to or upon admission of a resident, the assisted living facility shall explain and provide the resident with a copy of the Montana Long-Term Care Residents' Bill of Rights.
(2) Residents have the right to execute living wills and other advance health care directives, and to have those advance directives honored by the facility in accordance with law.
(3) Prior to admission of a resident, the assisted living facility must inform a potential resident in writing of:
(a) their right (at the individual's option) to make decisions regarding medical care, including the right to accept or refuse medical treatment, and the right to formulate an advance directive; and
(b) explain and provide a copy of the facility's policies regarding advance directives, including a policy that the facility cannot implement an advance directive, either because of a conscientious objection (under 50-9-203, MCA), or, for some other reason as stated in facility policy (under 50-9-203, MCA).
(4) If the facility policy is not to implement an advanced directive the facility shall:
(a) take all reasonable steps to transfer the resident to a facility which has no prohibition against implementation of advance directives; or
(b) shall inform the resident in writing of any limitations placed upon implementation of the resident's advance directive by the facility.
(5) An assisted living facility may not require an execution of an advance directive as a condition for admission.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2829 RESIDENT FILE
(1) At the time of admission, a separate file must be established for each category A, category B or category C resident. This file must be maintained on site in a safe and secure manner and must preserve the resident's confidentiality.
(2) The file shall include at least the following:
(a) the resident application form;
(b) a completed resident agreement, in accordance with ARM 37.106.2823;
(c) updates of resident/provider agreements, if any;

(d) the service plan for all category A residents;
(e) resident's weight on admission and at least annually thereafter for category A residents or more often as the resident, or the resident's licensed health care professional, determine a weight check is necessary;
(f) reports of significant events including:
(i) the provider's response to the event;
(ii) steps taken to safeguard the resident; and
(iii) facility contacts with family members or another responsible party;
(g) a record of communication between the facility and the resident or their representative if there has been a change in the resident's status or a need to discharge; and
(h) the date and circumstances of the resident's final transfer, discharge, or death, including notice to responsible parties and disposition of personal possessions.
(3) The resident file must be kept current. The file must be retained for a minimum of three years following the resident's discharge, transfer or death.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2830 THIRD PARTY SERVICES

(1) A resident may purchase third party services provided by an individual or entity, licensed if applicable, to provide health care services under arrangements made directly with the resident or resident's legal representative under the provisions of 50-5-225(2)(a) and (b), MCA.
(2) The resident or resident's legal representative assumes all responsibility for arranging for the resident's care through appropriate third parties.
(3) Third party services shall not compromise the assisted living facility operation or create a danger to others in the facility.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2831 RESIDENT ACTIVITIES

(1) A planned, diversified program of resident activities shall be offered daily for residents, including individual or group activities, on or off site, to meet the individual needs and well being of residents. Resident activities should promote and encourage self care and continuity of normal activities.
(2) The activities program shall be developed based on the activity needs and interest of residents as identified through the service plan.
(3) The facility shall provide directly, or by arrangement, local transportation for each resident to and from health care services provided outside the facility and to activities of social, religious or community events in which the resident chooses to participate according to facility policy.
(4) The activities program shall develop and post a monthly group activities calendar, which lists social, recreational, and other events available to residents. The facility shall maintain a record of past monthly activities, kept on file on the premises for at least three months.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

Rules 32 through 34 reserved

37.106.2835 RESIDENT UNITS

(1) A resident of an assisted living facility who uses a wheelchair or walker for mobility, or who is a category B or category C resident, must not be required to use a bedroom on a floor other than the first floor of the facility that is entirely above the level of the ground, unless the facility is designed and equipped in such a manner that the resident can move between floors or to an adjacent international conference of building code officials approved occupancy/fire barrier without assistance and the below grade resident occupancy is or has been approved by the local fire marshal.

(2) Each resident bedroom must satisfy the following requirements:

(a) in a previously licensed facility, no more than four residents may reside in a single bedroom;

(b) in new construction and facilities serving residents with severe cognitive impairment, occupancy must be limited to no more than two residents per room;

(c) exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules, each single bedroom must contain at least 100 square feet, and each multi-bedroom must contain at least 80 square feet per resident;

(d) each resident must have a wardrobe, locker, or closet with minimum clear dimensions of one foot 10 inches in depth by one foot eight inches in width, with a clothes rod and shelf placed to permit a vertically clear hanging space of five feet for full length garments;

(e) a sufficient number of electrical outlets must be provided in each resident bedroom and bathroom to meet staff and resident needs without the use of extension cords;

(f) each resident bedroom must have operable exterior windows which meet the approval of the local fire or building code authority having jurisdiction;

(g) the resident's room door may be fitted with a lock if approved in the resident service plan, as long as facility staff have access to a key at all times in case of an emergency. Deadbolt locks are prohibited on all resident rooms. Resident room door locks must be operable, on the resident side of the door, with a single motion and may not require special knowledge for the resident to open;

(h) kitchens or kitchenettes in resident rooms are permitted if the resident's service plan permits unrestricted use and the cooking appliance can be removed or disconnected if the service plan indicates the resident is not capable of unrestricted use.

(3) A hallway, stairway, unfinished attic, garage, storage area or shed or other similar area of an assisted living facility must not be used as a resident bedroom. Any other room must not be used as a resident bedroom if it:

(a) can only be reached by passing through a bedroom occupied by another resident;

(b) does not have an operable window to the outside; or

(c) is used for any other purpose.

(4) Any provision of this rule may be waived at the discretion of the department if conditions in existence prior to the adoption of this rule or construction factors would make compliance extremely difficult or impossible and if the department determines that the level of safety to residents and staff is not diminished.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2836 FURNISHINGS

(1) Each resident in an assisted living facility must be provided the following at a minimum by the facility:

(a) an individual towel rack;

(b) a handicap accessible mirror mounted or secured to allow for convenient use by both wheelchair bound residents and ambulatory persons;

(c) clean, flame-resistant or non-combustible window treatments or equivalent, for every bedroom window;

(d) an electric call system comprised of a fixed manual, pendant cordless or two way interactive, UL or FM listed system which must connect resident rooms to the care staff center or staff pagers; and

(e) for each multiple-bed room, either flame-resistant privacy curtains for each bed or movable flame-resistant screens to provide privacy upon the request of a resident.

(2) Following the discharge of a resident, all of the equipment and bedding used by that resident and owned by the facility must be cleaned and sanitized.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2837 COMMON USE AREAS

(1) The facility must provide:

(a) a dining room of sufficient size to accommodate all the residents comfortably with dining room furnishings that are well constructed and tables designed to accommodate the use of wheelchairs;

(b) at least one centrally located common area in which residents may socialize and participate in recreational activities. A common area may include, without limitation, a living room, dining room, enclosed porch or solarium. The common area must be large enough to accommodate those to be served without overcrowding; and

(c) enough total living or recreational and dining room area to allow at least 30 square feet per resident.

(2) All common areas must be furnished and equipped with comfortable furniture and reading lights in quantities sufficient to accommodate those to be served.

(3) Any provision of this rule may be waived at the discretion of the department if conditions in existence prior to the adoption of this rule or construction factors would make compliance extremely difficult or impossible and if the department determines that the level of safety to residents and staff is not diminished.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

37.106.2838 RESIDENT TOILETS AND BATHING

(1) The facility shall provide:

(a) at least one toilet for every four residents;

(b) one bathing facility for every 12 residents; and

(c) a toilet and sink in each toilet room.

(2) All resident rooms with toilets or shower/bathing facilities must have an operable window to the outside or must be exhausted to the outside by a mechanical ventilation system.

(3) Each resident room bathroom shall:

(a) be in a separate room with a toilet. A sink need not be in the bathroom but shall be in close proximity to the toilet. A shower or tub is not required if the facility utilizes a central bathing unit or units; and
(b) have at least one towel bar per resident, one toilet paper holder, one accessible mirror and storage for toiletry items.
(4) All doors to resident bathrooms shall open outward or slide into the wall and shall be unlockable from the outside.
(a) Dutch doors, bi-folding doors, sliding pocket doors and other bi-swing doors may be used if they do not impede the bathroom access width and are approved by the department. A shared bathroom with two means of access is also acceptable.
(5) In rooms used by category C or other special needs residents, the bathroom does not have to be in a separate room and does not require a door.
(6) Each resident must have access to a toilet room without entering another resident's room or the kitchen, dining or living areas.
(7) Each resident bathroom or bathing room shall have an emergency call system reporting to the staff location with an audible signal. The device must be silenced at the location only and shall be accessible to an individual collapsed on the floor.
(8) Any provision of this rule may be waived at the discretion of the department if conditions in existence prior to December 27, 2002, or construction factors would make compliance extremely difficult or impossible and if the department determines that the level of safety to residents and staff is not diminished.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2839 ENVIRONMENTAL CONTROL
(1) The assisted living facility shall provide a clean, comfortable and well maintained home that is safe for residents and employees at all times.
(2) A minimum of 10 foot candles of light must be available in all rooms, with the following exceptions:
(a) all reading lamps must have a capacity to provide a minimum of 30 foot candles of light;
(b) all toilet and bathing areas must be provided with a minimum of 30 foot candles of light;
(c) general lighting in food preparation areas must be a minimum of 30 foot candles of light; and
(d) hallways must be illuminated at all times by at least a minimum of five foot candles of light at the floor.
(3) Temperature in resident rooms, bathrooms, and common areas must be maintained at a minimum of 68°F.
(4) A resident's ability to smoke safely shall be evaluated and addressed in the resident's service or health care plan. If the facility permits resident smoking:
(a) the rights of non-smoking residents shall be given priority in settling smoking disputes between residents; and
(b) if there is a designated smoking area within the facility, it shall be designed to keep all contiguous, adjacent or common areas smoke free.

(5) An assisted living facility may designate itself as non-smoking provided that adequate notice is given to all residents or all applicants in the facility residency agreement. (History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

Rules 40 through 42 reserved

37.106.2843 PERSONAL CARE SERVICES

(1) Personal care assistance must be provided to each resident in accordance with their established agreement and needs. Assistance must include, but is not limited to assisting with:

(a) personal grooming such as bathing, hand washing, shaving, shampoo and hair care, nail filing or trimming and dressing;

(b) oral hygiene or denture care;

(c) toileting and toilet hygiene;

(d) eating;

(e) the use of crutches, braces, walkers, wheelchairs or prosthetic devices, including vision and hearing aids; and

(f) self-medication.

(2) Evidence that the facility is meeting each resident's needs for personal care services include the following outcomes for residents:

(a) physical well being of the resident means the resident:

(i) has clean and groomed hair, skin, teeth and nails;

(ii) is nourished and hydrated;

(iii) is free of pressure sores, skin breaks or tears, chaps and chaffing;

(iv) is appropriately dressed for the season in clean clothes;

(v) risk of accident, injury and infection has been minimized; and

(vi) receives prompt emergency care for illnesses, injuries and life threatening situations;

(b) behavioral and emotional well being of the resident includes:

(i) an opportunity to participate in age appropriate activities that are meaningful to the resident if desired;

(ii) a sense of security and safety;

(iii) a reasonable degree of contentment; and

(iv) a feeling of stable and predictable environment;

(c) unless medically required by a physician or other practitioner's written order, the resident is:

(i) free to go to bed at the time desired;

(ii) free to get up in the morning at the time desired;

(iii) free to have visitors;

(iv) granted privacy;

(v) assisted to maintain a level of self care and independence;

(vi) assisted as needed to have good oral hygiene;

(vii) made as comfortable as possible by the facility;

(viii) free to make choices and assumes the risk of those choices;

(ix) fully informed of the services that are provided by the facility;

(x) free of abuse, neglect and exploitation;

(xi) treated with dignity; and

(xii) given the opportunity to participate in activities, if desired.
(3) In the event of accident or injury to a resident requiring emergency medical, dental or nursing care or, in the event of death, the assisted living facility shall:
(a) immediately make arrangements for emergency care or transfer to an appropriate place for treatment;
(b) immediately notify the resident's practitioner and the resident's legal representative.
(4) A resident shall receive skin care that meets the following standards:
(a) the facility shall practice preventive measures to identify those at risk and maintain a resident's skin integrity.
Risk factors include:
(i) skin redness lasting more than 30 minutes after pressure is relieved from a bony prominence, such as hips, heels, elbows or coccyx; and
(ii) malnutrition/dehydration, whether secondary to poor appetite or another disease process; and
(b) an area of broken or damaged skin must be reported within 24 hours to the resident's practitioner. Treatment must be provided as ordered by the resident's practitioner.
(5) A person with a stage 3 or 4 pressure ulcer may not be admitted or permitted to remain in a category A facility.
(6) The facility shall ensure records of observations, treatments and progress notes are entered in the resident's record and that services are in accordance with the resident health care plan.
(7) Direct care staff shall receive training related to maintenance of skin integrity and the prevention of pressure sores by:
(a) keeping residents clean and dry;
(b) providing residents with clean and dry bed linens;
(c) keeping residents well hydrated;
(d) maintaining or restoring healthy nutrition; and
(e) keeping the residents physically active and avoiding the overuse of wheelchairs, sitting no longer than one hour or remaining in one position for longer than two hours at one time, and other sources of skin breakdown in ADLs.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
Rules 44 and 45 reserved
37.106.2846 MEDICATIONS: STORAGE AND DISPOSAL
(1) With the exception of resident medication organizers as discussed in ARM 37.106.2848, all medication must be stored in the container dispensed by the pharmacy or in the container in which it was purchased in the case of over-the-counter medication, with the label intact and clearly legible.
(2) Medications that require refrigeration must be segregated from food items and stored within the temperature range specified by the manufacturer.
(3) All medications administered by the facility shall be stored in locked containers in a secured environment such as a medication room or medication cart. Residents who are responsible for their own medication administration must be provided with a secure storage place within their room for their medications. If the resident is in a private room, locking the door when the resident leaves will suffice.

(4) Over-the-counter medications or home remedies requested by the resident shall be reviewed by the resident's practitioner or pharmacist as part of the development of a resident's service plan. Residents may keep over-the-counter medications in their room with a written order by the residents' practitioners.
(5) The facility shall develop and implement a policy for lawful disposal of unused, outdated, discontinued or recalled resident medications. The facility shall return a resident's medication to the resident or resident's legal representative upon discharge.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2847 MEDICATIONS: PRACTITIONER ORDERS

(1) Medication and treatment orders shall be carried out as prescribed. The resident has the right to consent to or refuse medications and treatments. The practitioner shall be notified if a resident refuses consent to an order. Subsequent refusals to consent to an order shall be reported as required by the practitioner.
(2) A prescription medication for which the dose or schedule has been changed by the practitioner must be noted in the resident's medication administration record and the resident's service or health care plan by an appropriate licensed health care professional.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2848 MEDICATIONS: ADMINISTRATION AND PREPARATION

(1) All category A facility residents must self-administer their medication. Those category B facility residents that are capable of, and who wish to self-administer medications, shall be encouraged by facility staff to do so.
(2) Any direct care staff member who is capable of reading medication labels may be made responsible for providing necessary assistance to any resident in taking their medication, as defined in ARM 37.106.2805.
(3) Resident medication organizers may be prepared up to four weeks in advance and injectable medications as specified in
(4)(c) by the following individuals:
(a) a resident or a resident's legal representative;
(b) a resident's family care giver, who is a person related to the resident by blood or marriage or who has full guardianship; or
(c) as otherwise provided by law.
(4) The individual referred to in (3) must adhere to the following protocol:
(a) verify that all medications to be set up carry a practitioner's current order;
(b) set up medications only from prescriptions in labeled containers dispensed by a registered pharmacist or from overthe- counter drug containers with intact, clearly readable labels; and
(c) set up injectable insulin up to seven days in advance by drawing insulin into syringes identified for content, date and resident. Other injectable medications must be set up according to the recommendations provided by the pharmacy.

(5) The facility may require residents to use a facility approved medication dispensing system or to establish medication set up criteria, but shall not require residents to purchase prescriptions from a specific pharmacy.
(6) No resident or staff member may be permitted to use another resident's medication.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.) 37-26612 12/31/02

37.106.2849 MEDICATIONS: RECORDS AND DOCUMENTATION

(1) An accurate medication record for each resident shall be kept of all medications, including over-the-counter medications, for those residents whose self-administration of medication requires monitoring and/or assistance by the facility staff.
(2) The record shall include:
(a) name of medication, reason for use, dosage, route and date and time given;
(b) name of the prescribing practitioner and their telephone number;
(c) any adverse reaction, unexpected effects of medication or medication error, which must also be reported to the resident's practitioner;
(d) allergies and sensitivities, if any;
(e) resident specific parameters and instructions for PRN medications;
(f) documentation of treatments with resident specific parameters;
(g) documentation of doses missed or refused by resident and why;
(h) initials of the person monitoring and/or assisting with self-administration of medication; and
(i) review date and name of reviewer.
(3) The facility shall maintain legible signatures of staff who monitor and/or assist with the self-administration of medication, either on the medication administration record or on a separate signature page.
(4) A medication record need not be kept for those residents for whom written authorization has been given by their practitioner to keep their medication in their rooms and to be fully responsible for taking the medication in the correct dosage and at the proper time. The authorization must be renewed on an annual basis.
(5) The facility shall maintain a record of all destroyed or returned medications in the resident's record or closed resident file in the case of resident transfer or discharge.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

Rules 50 through 52 reserved

37.106.2853 OXYGEN USE

(1) A resident who requires the use of oxygen:
(a) shall be permitted to self-administer the oxygen if the resident is capable of:
(i) determining their need for oxygen; and
(ii) administering the oxygen to themselves or with assistance.
(2) The direct care staff employed by the facility shall monitor the ability of the resident to operate the equipment in accordance with the orders of the practitioner.
(3) The facility shall ensure that all direct care staff who may be required to assist resident's with administration of oxygen have demonstrated the ability to properly operate the equipment.
(4) The following rules must be followed when oxygen is in use:
(a) oxygen tanks must be secured and properly stored at all times;

(b) no smoking or open flames may be allowed in rooms in which oxygen is used or stored, and such rooms must be posted with a conspicuous "No Smoking, Oxygen in Use" sign;
(c) a backup portable unit for the administration of oxygen shall be present in the facility at all times when a resident who requires oxygen is present in the facility, this includes when oxygen concentrators are used;
(d) the equipment used to administer oxygen must be in good working condition; and
(e) the equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

37.106.2854 USE OF RESTRAINTS, SAFETY DEVICES, ASSISTIVE DEVICES, AND POSTURAL SUPPORTS

(1) The facility shall comply with the rules governing the use of restraints, safety devices, assistive devices and postural supports in long term care facilities. The provisions of ARM 37.106.2901, 37.106.2902, 37.106.2904, 37.106.2905 and 37.106.2908 shall apply.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

37.106.2855 INFECTION CONTROL

(1) The assisted living facility must establish and maintain infection control policies and procedures sufficient to provide a safe environment and to prevent the transmission of disease. Such policies and procedures must include, at a minimum, the following requirements:
(a) any employee contracting a communicable disease that is transmissible to residents through food handling or direct care must not appear at work until the infectious diseases can no longer be transmitted. The decision to return to work must be made by the administrator or designee, in accordance with the policies and procedures instituted by the facility;
(b) if, after admission to the facility, a resident is suspected of having a communicable disease that would endanger the health and welfare of other residents, the administrator or designee, must contact the resident's practitioner and assure that appropriate safety measures are taken on behalf of that resident and the other residents; and
(c) all staff shall use proper hand washing technique after providing direct care to a resident.
(2) The facility, where applicable, shall comply with applicable statutes and rules regarding the handling and disposal of hazardous waste.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

Rules 56 through 58 reserved

37.106.2859 PETS

(1) Unless the facility disallows it, residents in an assisted living facility may keep household pets, as permitted by local ordinance, subject to the following provisions:
(a) pets must be clean and disease-free;
(b) the immediate environment of pets must be kept clean;

(c) birds must be kept in appropriate enclosures, unless the bird is a companion breed maintained and supervised by the owner; and
(d) pets that are kept at the facility shall have documentation of current vaccinations, including rabies, as appropriate.
(2) The administrator or designee shall determine which pets may be brought into the facility. Upon approval, family members may bring pets to visit, if the pets are clean, disease-free and vaccinated as appropriate.
(3) Facilities that allow birds shall have procedures that protect residents, staff and visitors from psittacosis, ensure minimum handling of droppings and require droppings to be placed in a plastic bag for disposal.
(4) Prior to admission of companion birds, documentation of the import, out-of-state veterinarian health certificate and import permit number provided by the pet store or breeder will be provided and maintained in the owners records. If the health certificate and import permit number is not available, or if the bird was bred in-state, a certificate from a veterinarian stating that the bird is disease free is required prior to residency. If the veterinarian certificate cannot be obtained by the move-in date the resident may keep the bird enclosed in a private single occupancy room, using good hand washing after handling the bird and bird droppings until the veterinarian examination is obtained.
(5) Pets may not be permitted in food preparation, storage or dining areas during meal preparation time or during meal service or in any area where their presence would create a significant health or safety risk to others.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2860 FOOD SERVICE
(1) The facility must establish and maintain standards relative to food sources, refrigeration, refuse handling, pest control, storage, preparation, procuring, serving and handling food and dish washing procedures that are sufficient to prevent food spoilage and the transmission of infectious disease. These standards must include the following:
(a) food must be obtained from sources that comply with all laws relating to food and food labeling;
(b) the use of home-canned foods is prohibited;
(c) food subject to spoilage removed from its original container, must be kept sealed, labeled, and dated.
(2) Foods must be served in amounts and a variety sufficient to meet the nutritional needs of each resident. The facility must provide therapeutic diets when prescribed by the resident's practitioner. At least three meals must be offered daily and at regular times, with not more than a 14-hour span between an evening meal and breakfast unless a nutritious snack is available in the evening, then up to 16 hours may lapse between a substantial evening meal and breakfast.
(3) Records of menus as served must be filed on the premises for three months after the date of service for review by the department.
(4) The facility shall take into consideration them preferences of the residents and the need for variety when planning the menu. Either the current day or the current week's menu shall be posted for resident viewing.

(5) The facility shall employ food service personnel suitable to meet the needs of the residents.
(a) Foods must be cut, chopped and ground to meet individual needs or as ordered by the resident's physician or practitioner;
(b) if the cook or other kitchen staff must assist a resident with direct care outside the food service area, they must properly wash their hands before returning to food service; and
(c) food service shall comply with the Montana administrative rule requirements for compliance with ARM Title 37, chapter 110, subchapter 2, food service establishments administered by the food and consumer safety section of the department of public health and human services.
(6) If the facility admits residents requiring therapeutic or special diets, the facility shall have an approved dietary manual for reference when preparing a meal. Dietitian consultation shall be provided as necessary and documented for residents requiring therapeutic diets.
(7) A minimum of a one-week supply of non-perishable foods and a two-day supply of perishable foods must be available on the premises.
(8) Potentially hazardous food, such as meat and milk products, must be stored at 41°F or below. Hot food must be kept a 140°F or above during preparation and serving.
(9) Freezers must be kept at a temperature of 0°F or below and refrigerators must be kept at a temperature of 41°F or below. Thermometers must be placed in the warmest area of the refrigerator and freezer to assure proper temperature. Temperatures shall be monitored and recorded at least once a month in a log maintained at the facility for one year.
(10) Employees shall maintain a high degree of personal cleanliness and shall conform to good hygienic practice during all working periods in food service.
(11) A food service employee, while infected with a disease in a communicable form that can be transmitted by foods may not work in the food service area.
(12) Tobacco products may not be used in the food preparation and kitchen areas.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

37.106.2861 LAUNDRY

(1) Laundry service must be provided by the facility, either on the premises or off the facility site.
(2) If an assisted living facility processes its laundry on the premises it must:
(a) equip the laundry room with a mechanical washer and a dryer vented to the outside, hand washing facilities, a fresh air supply and a hot water supply system which supplies the washer with water of at least 110°F during each use;
(b) have ventilation in the sorting, holding and processing area that shall be adequate to prevent heat and odor build-up;
(c) dry all bed linen, towels and washcloths in a dryer; and
(d) ensure that facility staff handling laundry wash their hands both after working with soiled laundry and before they handle clean laundry.
(3) Resident's personal clothing must be laundered by the facility unless the resident or the resident's family accepts this responsibility. If the facility launders the resident's

personal clothing, the facility is responsible for returning the clothing. Residents capable of laundering their own personal clothing and wishing to do so shall be provided the facilities and necessary assistance by the facility.
(4) The facility shall provide a supply of clean linen in good condition at all times that is sufficient to change beds often enough to keep them clean, dry and free from odors. Facility provided linens must be changed at least once a week and more often if the linens become dirty. In addition, the facility must ensure that each resident is supplied with clean towels and washcloths that are changed at least twice a week, a moisture-proof mattress cover and mattress pad, and enough blankets to maintain warmth and comfort while sleeping.
(5) Residents may use their own linen in the facility if they choose.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2862 HOUSEKEEPING
(1) The following housekeeping rules must be followed:
(a) Supplies and equipment must be properly stored and must be on hand in a quantity sufficient to permit frequent cleaning of floors, walls, woodwork, windows and screens;
(b) Housekeeping personnel must be trained in proper procedures for preparing cleaning solutions, cleaning rooms and equipment and handling clean and soiled linen, trash and trays;
(c) Cleaners used in cleaning bathtubs, showers, lavatories, urinals, toilet bowls, toilet seats and floors must contain fungicides or germicides with current EPA registration for that purpose; and
(d) Garbage and trash must be stored for final disposal in areas separate from those used for preparation and storage of food and must be removed from the facility daily. Garbage containers must be kept clean.
(i) Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by vermin. These containers shall be emptied daily and kept clean.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)
Rules 63 and 64 reserved
37.106.2865 PHYSICAL PLANT
(1) An assisted living facility must be constructed and maintained so as to prevent as much as possible the entrance and harborage of rats, mice, insects, flies and other vermin.
(2) The facility and facility grounds shall be kept orderly and free of litter and refuse and secure from hazards.
(3) When required by the building code authority having jurisdiction, at least one primary grade level entrance to the facility shall be arranged to be fully accessible to disabled persons.
(4) All exterior pathways or accesses to the facility's common use areas and entrance and exit ways shall be of hard, smooth material, accessible and be maintained in good repair.
(5) All interior or exterior stairways used by residents shall have sturdy handrails on one side installed in accordance with the uniform building code with strength and anchorage

sufficient to sustain a concentrated 250-pound load to provide residents safety with ambulation.
(6) All interior and exterior materials and surfaces (e.g., floors, walls, roofs, ceilings, windows and furniture) and all equipment necessary for the health, safety and comfort of the resident shall be kept clean and in good repair.
(7) Carpeting and other floor materials shall be constructed and installed to minimize resistance for passage of wheelchairs and other ambulation aids. Thresholds and floor junctures shall also be designed and installed for passage of wheelchairs and to prevent a tripping hazard.
(8) The facility shall install grab bars at each toilet, shower, sitz bath and tub with a minimum of one and one half inches clearance between the bar and the wall and strength and anchorage sufficient to sustain a concentrated 250-pound load. If a toilet grab bar assist is used over a toilet, it must be safely stabilized and secured in order to prevent mishap.
(9) Any structure such as a screen, half wall or planter which a resident could use for support while ambulating shall be securely anchored.
(10) The bottoms of tubs and showers must have surfaces that inhibit falling and slipping.
(11) Hand cleansing soap or detergent and single use individual towels must be available at each sink in the commonly shared areas of the facility. A waste receptacle must be located near each sink. Cloth towels and bar soap for common use are not permitted.
(12) Hot water temperature supplied to hand washing, bathing and showering areas may not exceed 120°F.
(13) The facility shall provide locked storage for all poisons, chemicals, rodenticides, herbicides, insecticides and other toxic material. Hazardous material safety sheets and labeling shall be kept available for staff for all such products used and stored in the facility.
(14) Flammable and combustible liquids shall be safely and properly stored in original or approved, properly labeled containers in areas inaccessible to residents in accordance with the uniform fire code in amounts acceptable to the fire code authority having jurisdiction.
(15) Containers used to store garbage in resident bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. Resident containers shall be emptied as needed, but at least weekly.
(16) If the facility utilizes a non-municipal water source, the water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or E. coli bacteria and corrective action is taken to assure the water is safe to drink. Documentation of testing is retained on the premises for 24 months from the date of the test.
(17) If a non-municipal sewage system is used, the sewage system must be in working order and maintained according to all applicable state laws and rules.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2866 CONSTRUCTION, BUILDING AND FIRE CODES
(1) Any construction of or alteration, addition, modification or renovation to an assisted living facility must meet the requirements of the building code and fire marshal agencies

having jurisdiction and be approved by the officer having jurisdiction to determine if the building and fire codes are met by the facility.
(2) When a change in use and building code occupancy classification occurs, licensure approval shall be contingent on meeting the building code and fire marshal agencies' standards in effect at the time of such a change. Changes in use include adding a category B or C license endorsement to a previously licensed category A facility.
(3) Changes in the facility location, use or number of facility beds cannot be made without written notice to, and written approval received from, the department.
(4) Exit doors shall not include locks which prevent evacuation, except as approved by the fire marshal and building codes agencies having jurisdiction.
(5) Stairways, halls, doorways, passageways and exits from rooms and from the building shall be kept unobstructed at all times.
(6) All operable windows and outer doors that may be left open shall be fitted with insect screens.
(7) An assisted living care facility must have an annual fire inspection conducted by the appropriate local fire authority or the state fire marshal's office and maintain a record of such inspection for at least three years following the date of the inspection.
(8) An employee and resident fire drill is conducted at least two times annually, no closer than four months apart and includes residents, employees and support staff on duty and other individuals in the facility. A resident fire drill includes making a general announcement throughout the facility that a resident fire drill is being conducted or sounding a fire alarm.
(9) Records of employee and resident fire drills are maintained on the premises for 24 months from the date of the drill and include the date and time of the drill, names of the employees participating in the drill and identification of residents needing assistance for evacuation.
(10) A 2A10BC portable fire extinguisher shall be available on each floor of a greater than 20 resident facility and shall be as required by the fire authority having jurisdiction for facilities of less than 20 residents.
(11) Portable fire extinguishers must be inspected, recharged and tagged at least once a year by a person certified by the state to perform such services.
(12) Smoke detectors installed and maintained per the manufacturer's directions shall be installed in all resident rooms, bedroom hallways, living room, dining room and other open common spaces or as required by the fire authority having jurisdiction. An annual maintenance log of battery changes and other maintenance services performed shall be kept in the facility and made available to the department upon request.
(13) If there is an inside designated smoking area, it shall be separate from other common areas, and provided with adequate mechanical exhaust vented to the outside.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)
Rules 67 through 71 reserved
37.106.2872 REQUIREMENTS FOR CATEGORY B FACILITIES ONLY
(1) An assisted living category B endorsement to the license shall be made by the licensing bureau of the department only after:
(a) initial department approval of the facility's category B policy and procedures;

(b) evidence of the administrator's and facility staff qualifications; and
(c) written approval from the building and fire code authorities having jurisdiction.
(2) An assisted living category B facility shall employ or contract with a registered nurse to provide or supervise nursing service to include:
(a) general health monitoring on each category B resident;
(b) performing a nursing assessment on category B residents when and as required;
(c) assistance with the development of the resident health care plan and, as appropriate, the development of the resident service plan; and
(d) routine nursing tasks, including those that may be delegated to licensed practical nurses (LPN) and unlicensed assistive personnel in accordance with the Montana Nurse Practice Act.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2873 ADMINISTRATOR QUALIFICATIONS: CATEGORY B

(1) An assisted living category B facility must be administered by a person who, in addition to the requirements found in ARM 37.106.2814, has one or more years experience working in the field of geriatrics or caring for disabled residents in a licensed facility.
(2) Providers in existence on the date of the final adoption of this rule will be granted one year to meet the category B administrator requirements found in (1).
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2874 DIRECT CARE STAFF QUALIFICATIONS: CATEGORY B

(1) In addition to the requirements found in ARM 37.106.2816, each nonprofessional staff providing direct care in an assisted living category B facility shall show documentation of in-house training related to the care and services they are to provide under direct supervision of a registered nurse or supervising nursing service providing category B care, including those tasks that may be delegated to licensed practical nurses (LPN) and unlicensed assistive personnel in accordance with the Montana Nurse Practice Act.
(2) Staff members whose job responsibilities will include supervising or preparing special or modified diets, as ordered by the resident's practitioner, shall receive training prior to performing this responsibility.
(3) Prior to providing direct care, direct care staff must:
(a) work under direct supervision for any direct care task not yet trained or properly oriented; and
(b) not take the place of the required certified person.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2875 RESIDENT HEALTH CARE PLAN: CATEGORY B

(1) Within 21 days of admission to a category B status, the administrator or designee shall assure that a written resident health care assessment is performed on each category B resident.

(2) Each initial health care assessment by the licensed health care professional shall include, at a minimum, evaluation of the following:
(a) cognitive status;
(b) communication/hearing patterns;
(c) vision patterns;
(d) physical functioning and structural problems;
(e) continence;
(f) psychosocial well being;
(g) mood and behavior patterns;
(h) activity pursuit patterns;
(i) disease diagnosis;
(j) health conditions;
(k) oral nutritional status;
(l) oral dental status;
(m) skin condition;
(n) medication use; and
(o) special treatment and procedures.
(3) A written resident health care plan shall be developed. The resident health care plan shall include, but not be limited to the following:
(a) a statement which informs the resident and the resident's practitioner, if applicable, of the requirements of 50-5-226(3) and (4), MCA.
(b) orders for treatment or services, medications and diet, if needed;
(c) the resident's needs and preferences for themselves;
(d) the specific goals of treatment or services, if appropriate;
(e) the time intervals at which the resident's response to treatment will be reviewed; and
(f) the measures to be used to assess the effects of treatment;
(g) if the resident requires care or supervision by a licensed health care professional, the health care plan shall include the tasks for which the professional is responsible.
(4) The category B resident's health care plan shall be reviewed, and if necessary revised upon change of condition.
(5) The health care plan shall be readily available to and followed by those staff and licensed health care professionals providing the services and health care.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)
Rules 76 through 78 reserved
37.106.2879 INCONTINENCE CARE: CATEGORY B
(1) In order to maintain normal bladder and bowel functions, the facility
shall provide individualized attention to each resident that meets the following minimum standards:
(a) the facility shall provide a resident who is incontinent of bowel or bladder adequate personal care services to maintain the person's skin integrity, hygiene and dignity and to prevent urinary tract infections.
(2) Evidence that the facility is meeting each resident's needs for maintaining normal bowel and bladder functions include the following outcomes for residents at risk for incontinence:

(a) the resident is checked during those periods when they are known to be incontinent, including the night;
(b) the resident is kept clean and dry;
(c) clean and dry bed linens are provided as needed; and
(d) if the resident can benefit from scheduled toileting, they are assisted or reminded to go to the bathroom at regular intervals.
(3) Indwelling catheters are permissible, if the catheter care is taught and supervised by a licensed health care professional under a practitioner's order. Observations and care must be documented.
(4) Facility staff shall not:
(a) withhold fluids from a resident to control incontinence; or
(b) have a resident catheterized to control incontinence for the convenience of staff.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)
37.106.2880 PREVENTION AND CARE OF PRESSURE SORES: CATEGORY B
(1) A resident shall receive skin care that meets the following standards:
(a) the facility shall practice preventive measures to identify those at risk and maintain a resident's skin integrity; and
(b) an area of broken or damaged skin must be reported within 24 hours to the resident's practitioner. Treatment must be as ordered by the resident's practitioner.
(2) A person with an open wound or having a pressure or stasis ulcer requiring treatment by a health care professional may not be admitted or permitted to remain in the facility unless:
(a) the wound is in the process of healing, as determined by a licensed health care professional, and is either:
(i) under the care of a licensed health care professional; or
(ii) can be cared for by the resident without assistance.
(3) The facility shall ensure records of observations, treatments and progress notes are entered in the resident record and that services are in accordance with the resident health care plan.
(4) No over the counter products such as creams, lotions, ointments, soaps, iodine or alcohol shall be put on an open pressure or stasis wound unless ordered by the resident's practitioner after an appropriate evaluation of the wound.
(5) Evidence the facility is meeting those resident's identified as a greater risk for skin care needs include the following outcomes for residents:
(a) the facility has identified those residents who are at greater risk of developing a pressure or stasis ulcer. Primary risk factors include but are not limited to:
(i) continuous urinary incontinence or chronic voiding dysfunction;
(ii) severe peripheral vascular disease (poor circulation to the legs);
(iii) diabetes;
(iv) chronic bowel incontinence;
(v) sepsis;
(vi) terminal cancer;
(vii) decreased mobility or confined to bed or chair;
(viii) edema or swelling of the legs;

(ix) chronic or end stage renal, liver or heart disease;
(x) CVA (stroke);
(xi) recent surgery or hospitalization;
(xii) any resident with skin redness lasting more than 30 minutes after pressure is relieved from a bony prominence, such as hips, heels, elbows or coccyx, is at extremely high risk in that area; and
(xiii) malnutrition/dehydration whether secondary to poor appetite or another disease process.
(b) direct care staff have received training related to maintenance of skin integrity and the prevention and care of pressure sores from a licensed health care professional who is trained to care for that condition;
(c) the resident's practitioner has diagnosed the condition and ordered treatment;
(d) the resident is kept clean and dry;
(e) the resident is provided clean and dry bed linens;
(f) the resident is kept hydrated;
(g) the resident is turned and repositioned;
(h) the wound is getting smaller;
(i) there is no evidence of infection;
(j) wound bed is moist, not dried out or scabbed over;
(k) the resident has less restriction of movement; and
(l) the resident's pain level has diminished.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)
Rules 81 through 83 reserved
37.106.2884 SEVERE COGNITIVE IMPAIRMENT: CATEGORY B (REPEALED)
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; REP, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2885 ADMINISTRATION OF MEDICATIONS: CATEGORY B
(1) Written, signed practitioner orders shall be documented in all category B resident facility records by a legally authorized person for all medications and treatments which the facility is responsible to administer. Medication or treatment changes shall not be made without a practitioner's order. Order changes obtained by phone must be confirmed by written, signed orders within 21 days.
(2) All medications administered to a B resident shall be administered by a licensed health care professional or by an individual delegated the task under the Nurse Practice Act and ARM Title 8, chapter 32, subchapter 17. Those category B residents, that are capable of self administration shall be given the opportunity and encouraged to do so.
(3) Residents with a standing PRN medication order, that cannot determine their own need for the medication by making a request to self-administer the medication or in the case of the cognitively impaired cannot respond to caretaker's suggestions for over-the-counter PRN pain medications shall:
(a) have the medication administered by a licensed health care professional after an assessment and the determination of need has been made; and

(b) be classified as a B resident because a nursing decision to determine the resident's need for the medication was required.
(4) Medication and treatment orders shall be carried out as prescribed. The resident or the person legally authorized to make health care decisions for the resident has the right to consent to, or refuse medications and treatments. The practitioner shall be notified if a resident refuses consent to an order. Subsequent refusals to consent to an order shall be reported as required by the practitioner.
(5) Only the following individuals may administer medications to residents:
(a) a licensed physician, physician's assistant, certified nurse practitioner, advanced practice registered nurse or a registered nurse;
(b) licensed practical nurse working under supervision;
(c) an unlicensed individual who is either employed by the facility or is working under third party contract with a resident or resident's legal representative and has been delegated the task under ARM Title 8, chapter 32, subchapter 17; and
(d) a person related to the resident by blood or marriage or who has full guardianship.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

37.106.2886 MEDICATIONS: RECORDS AND DOCUMENTATION: CATEGORY B

(1) An accurate medication record for each resident shall be kept of all medications, including over-the-counter medications, administered by the facility to that resident.
(2) The record shall include:
(a) name of medication, reason for use, dosage, route and date and time given;
(b) name of the prescribing practitioner and their telephone number;
(c) any adverse reaction, unexpected effects of medication or medication error, which must also be reported to the resident's practitioner;
(d) allergies and sensitivities, if any;
(e) resident specific parameters and instructions for PRN medications;
(f) documentation of treatments with resident specific parameters;
(g) documentation of doses missed or refused by resident and why; and
(h) initials of the person administering the medication and treatment at the time of administration.
(3) The facility shall maintain legible signatures of staff who administer medication or treatment, either on the medication administration record or on a separate signature page.
(4) A medication record need not be kept for those residents for whom written authorization has been given by their physician or practitioner to keep their medication in their rooms and to be fully responsible for taking the medication in the correct dosage and at the proper time. The authorization must be renewed on an annual basis.
(5) The facility shall maintain a record of all destroyed or returned medications in the resident's record or closed resident file in the case of resident transfer or discharge.
(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02.)

Rules 87 through 90 reserved

37.106.2891 ADMINISTRATOR QUALIFICATIONS: CATEGORY C

(1) An assisted living category C facility must be administered by a person who meets the conditions of ARM 37.106.2814 and has:

(a) three or more years experience in working in the field of geriatrics or caring for disabled residents in a licensed facility; or
(b) a documented combination of education and training that is equivalent to the experience required in (1), as determined by the department.
(2) At least eight of the 16 hours of annual continuing education the administrator must complete under ARM 37.106.2814
(3) shall pertain to caring for persons with severe
cognitive impairments.
(History: Sec. 50-5-103, 50-5-223 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226, 50-5-227 and 50-5-228, MCA; NEW, 2004 MAR p. 1146, Eff. 5/7/04.)
37.106.2892 DIRECT CARE STAFF: CATEGORY C
(1) In addition to meeting all other requirements for direct care staff stated in this subchapter, assisted living category C facility direct care staff must receive additional documented training in:
(a) the facility or unit's philosophy and approaches to providing care and supervision for persons with severe cognitive impairment;
(b) the skills necessary to care for, intervene and direct residents who are unable to perform activities of daily living;
(c) techniques for minimizing challenging behavior including:
(i) wandering;
(ii) hallucinations, illusions and delusions; and
(iii) impairment of senses;
(d) therapeutic programming to support the highest possible level of resident function including:
(i) large motor activity;
(ii) small motor activity;
(iii) appropriate level cognitive tasks; and
(iv) social/emotional stimulation;
(e) promoting residents' dignity, independence, individuality, privacy and choice;
(f) identifying and alleviating safety risks to residents;
(g) identifying common side effects and untoward reactions to medications; and
(h) techniques for dealing with bowel and bladder aberrant behaviors.
(2) Staff must remain awake, fully dressed and be available in the facility or on the unit at all times to provide supervision and care to the resident as well as to assist the residents in evacuation of the facility if a disaster occurs.
(History: Sec. 50-5-103, 50-5-223 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226, 50-5-227 and 50-5-228, MCA; NEW, 2004 MAR p. 1146, Eff. 5/7/04.)
Rules 93 and 94 reserved
37.106.2895 HEALTH CARE PLAN: CATEGORY C
(1) Within 21 days of admission of a resident to an assisted living category
C facility, a resident certification must be conducted, and a written health care plan shall be developed which meets the requirements of ARM 37.106.2875, and which also includes detailed assessment, therapeutic management and intervention techniques for the following behaviors and resident needs:
(a) memory;
(b) judgement;

(c) ability to care for oneself;
(d) ability to solve problems;
(e) mood and character changes;
(f) behavioral patterns;
(g) wandering; and
(h) dietary needs.
(History: Sec. 50-5-103, 50-5-223 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226, 50-5-227 and 50-5-228, MCA; NEW, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2896 DISCLOSURES TO RESIDENTS: CATEGORY C

(1) Each assisted living category C facility or unit must, prior to admission, inform the resident's legal representative in writing of the following:
(a) the overall philosophy and mission of the facility regarding meeting the needs of residents afflicted with severe cognitive impairment and the form of care or treatment offered;
(b) the process and criteria for move-in, transfer and discharge;
(c) the process used for resident assessment;
(d) the process used to establish and implement a health care plan, including how the health care plan will be updated in response to changes in the resident's condition;
(e) staff training and continuing education practices;
(f) the physical environment and design features appropriate to support the functioning of cognitively impaired residents;
(g) the frequency and type of resident activities;
(h) the level of involvement expected of families and the availability of support programs; and
(i) any additional costs of care or fees.
(2) The facility must obtain from the resident's legal representative a written acknowledgment that the information specified in (1) was provided. A copy of this written acknowledgment must be kept as part of the permanent resident file.
(History: Sec. 50-5-103, 50-5-223 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226, 50-5-227 and 50-5-228, MCA; NEW, 2004 MAR p. 1146, Eff. 5/7/04.)

Rule 97 reserved

37.106.2898 REQUIREMENTS FOR SECURED UNITS: CATEGORY C

(1) In addition to meeting all other requirements for assisted living facilities stated in this subchapter, if a secured distinct part or locked unit within a category C assisted living facility is designated for the exclusive use of residents with severe cognitive impairment, the facility must:
(a) staff the unit with direct care staff at all times there are residents in the unit;
(b) provide a separate dining area, at a ratio of 30 square feet per resident on the unit; and
(c) provide a common day or activities area, at a ratio of 30 square feet per resident on the unit. The dining area listed in (1)(b) or day rooms, sun porches and common areas accessible to all residents, may serve this purpose.
(History: Sec. 50-5-103, 50-5-223 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226, 50-5-227 and 50-5-228, MCA; NEW, 2004 MAR p. 1146, Eff. 5/7/04.)

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHAPTER 106
HEALTH CARE FACILITIES
Subchapter 29
Restraints, Safety Devices, Assistive Devices, and Postural Supports
Rule 37.106.2901 Rule Applicability
37.106.2902 Definitions
Rule 03 reserved
37.106.2904 Use of Restraints, Safety Devices, Assistive Devices, and Postural Supports
37.106.2905 Documentation in Resident's Medical Records
Rules 06 and 07 reserved
37.106.2908 Staff Training

37.106.2901 RULE APPLICABILITY

(1) The provisions of the rules in this subchapter that govern the use of restraints do not apply to a category A personal care facility as defined in 50-5-227(2)(a), MCA, because such a facility is prohibited by law from accepting and serving any resident who is in need of medical, chemical or physical restraint.

(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5-1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1202 and 50-5-1203, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)

37.106.2902 DEFINITIONS The following definitions, in addition to those contained in 50-5-1202, MCA, apply to this chapter:

(1) "Assistive device" means any device whose primary purpose is to maximize the independence and the maintenance of health of an individual who is limited by physical injury or illness, psychosocial dysfunction, mental illness, developmental or learning disability, the aging process, cognitive impairment or an adverse environmental condition. If the device is primarily used to restrict an individual's movement, it is considered a safety device or restraint rather than an assistive device.

(2) "Licensed health care professional" means a physician, a physician assistant-certified, a nurse practitioner or a registered or practical nurse licensed in the state of Montana.

(3) "Medical symptom", as defined in 50-5-1202, MCA, means an indication of a physical or psychological condition or of a physical or psychological need expressed by the patient. For example, a concern for the resident's physical safety by any person listed in 50-5-1201(1), MCA, or a resident's fear of falling may constitute a medical symptom.

(4) "Postural support" means an appliance or device used to achieve proper body position and balance, to improve a resident's mobility and independent functioning, or to position rather than restrict movement, including, but not limited to, preventing a resident from falling out of a bed or chair. A postural support does not include tying a resident's hands or feet or otherwise depriving a resident of their use.

(5) "Restraint" means any method (chemical or physical) of restricting a person's freedom of movement that prevents them from independent and purposeful functioning. This includes seclusion, controlling physical activity, or restricting normal access to the resident's body that is not a usual and customary part of a medical diagnostic or treatment procedure to which the resident or the authorized representative has consented.

(6) "Safety devices", as defined in 50-5-1202, MCA, means side rails, tray tables, seat belts and other similar devices. The department interprets that definition to mean that a

safety device is used to maximize the independence and the maintenance of health and safety of an individual by reducing the risk of falls and injuries associated with the resident's medical symptom.

(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5- 1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1202 and 50-5-1203, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)

Rule 03 reserved

37.106.2904 USE OF RESTRAINTS, SAFETY DEVICES, ASSISTIVE DEVICES, AND POSTURAL SUPPORTS

(1) The application or use of a restraint, safety device or postural support is prohibited except to treat a resident's medical symptoms and may not be imposed for purposes of coercion, retaliation, discipline or staff convenience.

(2) A restraint may be a safety device when requested by the resident or the resident's authorized representative or physician to reduce the risk of falls and injuries associated with a resident's medical symptoms and used in accordance with 50-5-1201, MCA.

(3) To the extent that a resident needs emergency care, restraints may be used for brief periods:

(a) to permit medical treatment to proceed unless the health care facility has been notified that the resident has previously made a valid refusal of the treatment in question; or

(b) if a resident's unanticipated violent or aggressive behavior places the resident or others in imminent danger, in which case the resident does not have the right to refuse the use of restraints. In this situation:

(i) the use of restraints is a measure of last resort to protect the safety of the resident or others and may be used only if the facility determines and documents that less restrictive means have failed;

(ii) the size, gender, physical, medical and psychological condition of the resident must be considered prior to the use of a restraint;

(iii) a licensed nurse shall contact a resident's physician for restraint orders within one hour of application of a restraint;

(iv) the licensed nurse shall document in the resident's clinical record the circumstances requiring the restraints and the duration; and

(v) a restrained resident must be monitored as their condition warrants, and restraints must be removed as soon as the need for emergency care has ceased and the resident's safety and the safety of others can be assured.

(4) In accordance with the Montana Long-Term Care Residents' Bill of Rights, the resident or authorized representative is allowed to exercise decision-making rights in all aspects of the resident's health care or other medical regimens, with the exception of the circumstances described in (3)(b).

(5) Single or two quarter bed rails that extend the entire length of the bed are prohibited from use as a safety or assistive device; however, a bed rail that extends from the head to half the length of the bed and used primarily as a safety or assistive device is allowed.

(6) Physician-prescribed orthopedic devices used as postural supports are not considered safety devices or restraints and are not subject to the requirements for safety devices and restraints contained in these rules.

(7) Whenever a restraint, safety device, or postural support is used that restricts or prevents a resident from independent and purposeful functioning, the resident must be

provided the opportunity for exercise and elimination needs at least every two hours, or more often as needed, except when a resident is sleeping.
(8) All methods of restraint, safety devices, assistive devices and postural supports must be properly fastened or applied in accordance with manufacturer's instructions and in a manner that permits rapid removal by the staff in the event of fire or other emergency.
(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5-1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1201, 50-5-1202 and 50-5-1204, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)

37.106.2905 DOCUMENTATION IN RESIDENT'S MEDICAL RECORDS

(1) Prior to the use of a restraint or safety device, the following items must be included in the resident's record:
(a) a consent form signed by the resident or authorized representative that includes documentation that:
(i) the resident or the resident's authorized representative was given a written explanation of the alternatives and any known risks associated with the use of the restraint or safety device;
(ii) cites any pre-existing condition that may place a patient at risk of injury; and
(b) written authorization from the resident's primary physician that specifies the medical symptom that the restraint or safety device is intended to address and the type of circumstances and duration under which the restraint or safety device is to be used.
(2) When a restraint or safety device is used, the following items must be documented in the resident's record:
(a) frequency of monitoring in accordance with documented facility policy;
(b) assessment and provision of treatment if necessary for skin care, circulation and range of motion; and
(c) any unusual occurrences or problems.
(3) During a quarterly re-evaluation, a facility must consider:
(a) using the least restrictive restraint or safety device to restore the resident to a maximum level of functioning;
(b) causes for the medical symptoms that led to the use of the restraint or safety device; and
(c) alternative safety measures if a restraint or safety device is removed. Before removing a restraint or safety device, the resident or the authorized representative and the attending physician must be consulted.
(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5-1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1201, 50-5-1203 and 50-5-1204, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)

Rules 06 and 07 reserved

37.106.2908 STAFF TRAINING

(1) Restraints, safety devices or postural supports may only be applied by staff who have received training in their use, as specified below and appropriate to the services provided by the facility.
(2) Staff training shall include, at a minimum, information and demonstration in:
(a) the proper techniques for applying and monitoring restraints, safety devices or postural supports;
(b) skin care appropriate to prevent redness, breakdown and decubiti;

(c) active and passive assisted range of motion to prevent joint contractures;
(d) assessment of blood circulation to prevent obstruction of blood flow and promote adequate circulation to all extremities;
(e) turning and positioning to prevent skin breakdown and keep the lungs clear;
(f) potential risk for residents to become injured or asphyxiated because the resident is entangled in a bed rail or caught between the bed rail and mattress if the mattress or mattress pad is ill-fitted or is out of position;
(g) provision of sufficient bed clothing and covering to maintain a normal body temperature;
(h) provision of additional attention to meet the physical, mental, emotional and social needs of the resident; and
(i) techniques to identify behavioral symptoms that may trigger a resident's need for a restraint or safety device and to determine possible alternatives to their use. These include:
(i) observing the intensity, duration and frequency of the resident's behavior;
(ii) identifying patterns over a period of time and factors that may trigger the behavior; and
(iii) determining if the resident's behavior is:
(A) new or if there is a prior history of the behavior;
(B) the result of mental, emotional, or physical illness;
(C) or a radical departure from the resident's normal personality.
(3) Training described in (2) must meet the following
criteria:
(a) training must be provided by a licensed health care professional or a social worker with experience in a health care facility; and
(b) a written description of the content of this training, a notation of the person, agency, organization or institution providing the training, the names of staff receiving the training, and the date of training must be maintained by the facility for two years.
(4) Refresher training for all direct care staff caring for restrained residents and applying restraints, safety devices or postural supports must be provided at least annually or more often as needed. The facility must:
(a) ensure that the refresher training encompasses the techniques described in (2) of this rule; and
(b) for two years after each training session, maintain a record of the refresher training and a description of the content of the training.
(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5-1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1204 and 50-5-1205, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)
Chapter 107 reserved